the MODERN HOSPITAL

VOLUME 65 NOVEMBER 1945 NUMBER 5

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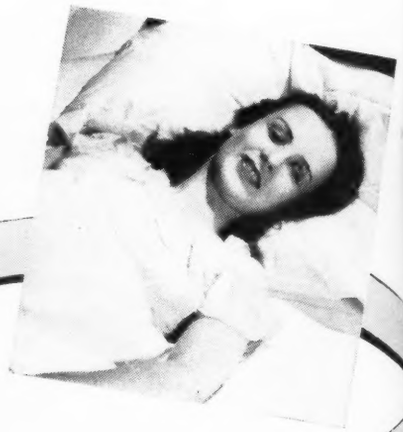

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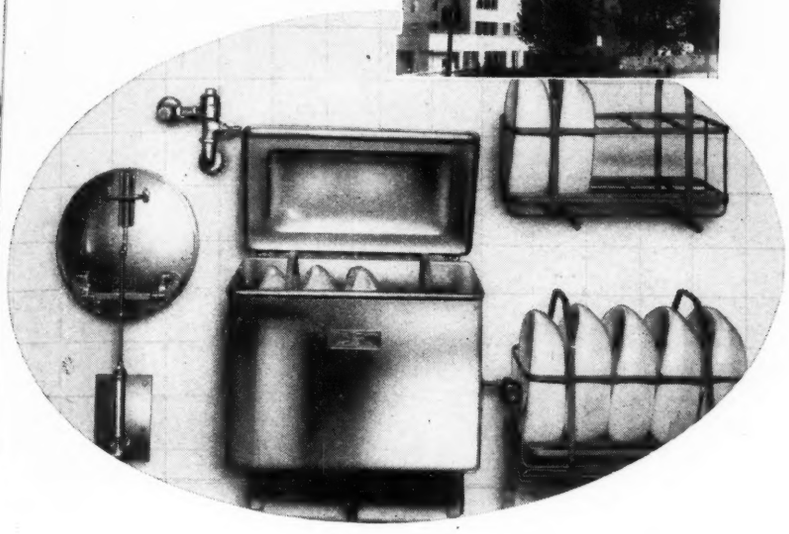

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CONTENTS

Published monthly and copyrighted, 1945. The Modern Hospital Publishing Company, Inc., 919 North Michigan Avenue, Chicago 11. Otho F. Ball, president; Raymond P. Sloan, vice president; Everett W. Jones, vice president; Stanley R. Clague, secretary; James G. Jarrett, treasurer. North and South America, $3 a year; foreign, $4. Single copies: current, 35c; back, 50c to $1. Entered as second-class matter, Oct. 1, 1918, at the post office at Chicago, Ill., under act of March 3, 1879. Printed in U.S.A.

ROBERT M. CUNNINGHAM JR.

Joins the Staff of The Modern Hospital

ROBERT M. CUNNINGHAM JR., associate editor of *Hygeia* since 1941, has been named managing editor of The MODERN HOSPITAL to succeed Alden B. Mills, who became superintendent of the Huntington Memorial Hospital of Pasadena, Calif., October 15.

Hygeia, the health magazine published by the American Medical Association, is designed to teach its readers important facts about health and to keep them abreast of scientific progress in medicine, nutrition, child care and related fields.

In addition to his work on *Hygeia,* Mr. Cunningham has been director of public relations for the Evanston Hospital Association of Evanston, Ill., since 1937. Throughout this period he has served as editor of the *Pilot,* one of the outstanding hospital house magazines in the United States. In addition, he has prepared publicity for the "Hospital Sunday" appeal made every February to raise funds for support of the hospital's charitable departments. For a little more than a year, Mr. Cunningham served full time at Evanston Hospital as director of public relations. During that year, he made a survey of population and economic trends in the hospital area, looking toward the expansion of hospital facilities.

Besides writing feature articles and a monthly column of medical news for *Hygeia,* Mr. Cunningham has written a number of articles on medical and related subjects for national magazines, including *Reader's Digest, Coronet,* the *New Republic, Parents' Magazine, Science Digest* and others.

Before he went to the American Medical Association in 1941, Mr. Cunningham was for three years a member of the staff of the Plan for Hospital Care in Chicago. While with Blue Cross, he served at various times as manager of enrollment and public relations and head of the hospital department.

During this period Mr. Cunningham was a member of the Chicago Hospital Council and its administrators' section, attended regional and national hospital meetings and contributed to hospital journals, including The MODERN HOSPITAL. He also spoke on Blue Cross subjects at several hospital meetings and served as chairman of one of the standing committees of the A.H.A.'s Commission on Hospital Service. For three years, Mr. Cunningham directed publicity for the Tri-State Hospital Assembly in Chicago.

Following graduation from the University of Chicago in 1931, Mr. Cunningham was a member of the staff of a public relations firm for two years and then became assistant to the president of Armour Institute of Technology, now the Illinois Institute of Technology, where he did public relations work and edited the institute's catalogs and other publications.

Mr. Cunningham is married and the father of four children; his home is in Glencoe, Ill., a suburb of Chicago.

GROUP MEDICINE

A Discussion of the Economics of Medical Care by

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SOCIAL SIGNIFICANCE—*Mackenzie*

DURING the years between World War I and 1929, Big Business and Big Finance, seeking larger profits, were busily integrating independent producing and distributing units to form large, often huge, corporations. Competitors were absorbed; costs of production were reduced; dividends and salaries were increased by pooling resources.

Influenced by the success of the mergers in the business world, American medicine became imitative. In the economics of medical care and in the professional relationships the merger trend of the market place expressed itself in what is commonly called group medicine or group medical practice. Prior to 1917 there had been, it is true, a few group medicine clinics, but the rapid increase in the number of these organizations occurred after 1919.

No brief definition of group medicine seems quite satisfactory. Groups differ widely in ownership, financial arrangements, kinds of medical service provided, educational atmosphere, hospital affiliations and, finally and most important, in commercialism, professional standards and quality of medical care.

The essential characteristics of what has come to be known as group medicine or group medical practice are pooling of the professional and material resources of three or more physicians and the provision of medical care by the collective effort of the group which is so organized that there are at least some division of labor and specialization and some form of pooling of receipts.

Often, several physicians with offices in the same building or in adjoining suites, practicing individually, have common secretarial, clerical, telephone and office nurse service. This is *not* group medicine; nor are many of the groups that are providing medical care for the individuals in a single industry.

There is perhaps some difference of opinion as to whether the groups providing medical care collectively in university clinics and as members of closed staffs of hospitals are doing group medicine. A considerable number of these arrangements are characterized, it would seem, by the essential components of group medicine—pooling of resources and receipts, collective effort, division of labor, some degree of specialization —and hence should not be excluded from a discussion of group medicine.

To refer to the foregoing, as some have done, as examples of group practice is, it should be confessed, a semantic error. In common and long-established usage the term "practice of medicine" implies that the physician has a financial stake in the patient he treats.

Any effort to survey group medicine as a whole and arrive at a trustworthy appraisal of the social significance of this conspicuous feature in the evolution of medical care in the United States should take into account the fact that among the vari-

ous group medicine arrangements there are at least three distinct categories. There are, to be sure, intermediate types and variants not easily and unequivocally classified, but it makes for clarification of the social, economic and educational importance of group medicine if the three main categories are considered separately and certain differentiating features are emphasized.

If we attempt to arrange the groups according to professional standards, educational atmosphere, quality of medical care, university affiliations, absence of commercialism — and these characteristics are often all present or all absent—we find, first, a number of coordinated groups working in out-patient clinics and full-time departments of the teaching hospitals of university medical schools. The University of Chicago Clinics and the New York University Clinic are good examples.

Medicine at Its Best

Generally, groups of this kind, by virtue of close and continuous academic relationships, maintain high professional standards, excellent traditions of scholarship and critical inquiry and an intellectually stimulating atmosphere and exhibit the least evidence of commercialism. These groups are examples of medicine at its best; they are bright ornaments of American medicine. In them and in a few similarly organized nonuniversity groups a close integration of library, laboratory and care of the patient has been achieved.

Usually they do not provide domiciliary care and most of them do not offer the public the opportunity of accurately budgeting medical expenses by prepayment plans. But the close association of clinicians with physiologists, biochemists and pathologists and their easy access to medical libraries elevate the quality of medical care to a level that tends to compensate for incomplete coverage and absence of prepayment plans.

A second category, consisting of about 400 group medicine organizations, frequently calling themselves clinics, is scattered principally throughout the Middle West, the South and the Pacific Coast. The spectacular success of the Mayo Clinic plus the merger psychology, with its emphasis on organization and business efficiency, led to the formation of most of these groups. In many of them one or more of the members had previously served on the staff of the Mayo Clinic.

Few were started, if their mode of operation justifies inferences regarding motivations, as social experiments. They have been largely unconcerned with the problem of adequate medical care for low-income families. They have various kinds of financial structures. Many of them, like the Lahey Clinic, are privately owned by a single individual or by a small inner circle and the other members of the staff have little or nothing to say about policies or division of profits and are employed on a salary basis, sometimes with a bonus if the proceeds justify it, or often without a bonus no matter what the profits are.

Some are complete partnerships; others consist of a partnership, which owns and controls the organization, and a number of physicians employed on a salary basis. Still others are corporations with varying numbers of the participating physicians holding stock, while in some instances there is the pernicious arrangement by which nonmedical outsiders own stock and participate in the profits.

Many of these groups own and operate proprietary hospitals. Available information does not permit an attempt to appraise the quality of medical care in these privately owned hospitals in comparison with that of voluntary and publicly owned hospitals. However, such surveys as those of Dr. and Mrs. Dean Clark, Rufus Rorem and the bureau of medical economics of the American Medical Association provide no evidence that medical libraries and adequate laboratories are important features of these institutions or that members of these groups have maintained continuing contact with biochemistry, physiology, bacteriology and pathology. Nor are internship appointments at a large majority of these proprietary hospitals given much consideration by the more capable graduates of the better medical schools.

So heterogeneous in respect to organization and professional orientation are the groups in this category that any attempt to generalize about them either would do an injustice to groups that maintain high standards of medical care or would cover unconcealed commercialism with a garment of implied commendation.

A few of these groups (for example, the Mary Hitchcock Memorial Hospital at Hanover, N. H., and the Nicollet Clinic in Minneapolis) benefit by academic relationships of the clinic as a whole or because of academic positions held by individual members of the group.

335 Groups Report Data

Gathering information by the questionnaire technic, the A.M.A. bureau of medical economics published detailed reports in 1933 and 1940 on "Group Medical Practice." The following data, taken chiefly from the 1940 report, are based on replies received from 335 groups which were all, or nearly all, in the category of group medicine organizations we are now discussing:

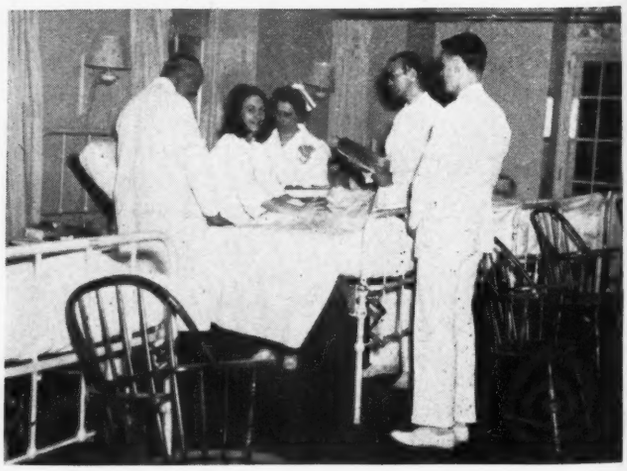
The number of physicians in these groups was 2093; more than half of the groups had only three or four physicians, but the average for the 335 groups was 6.2 physicians; the largest group had 67 physicians; 83 groups of 328 supplying information had some form of ownership relations with hospitals—ownership by the group, by one or more of its members or by corporations connected with the groups.

Associated with the groups were 101 dentists who, in a majority of cases, did not participate in the management of the group or share in its profits. There were 1355 nurses, 646 laboratory assistants and 2431 business and other employes in 331 groups.

Between 1932 and 1940 approximately 42 per cent of the groups in existence on the former date ceased to operate as groups; insofar as evidence was available the chief causes of dissolution were financial friction within the group and supposed financial disadvantage as compared with individual practice; 73 per cent of all groups were in cities of less than 50,000 population.

Group medicine plans in a third category have sprung, as in most of

Patients at Mary Imogene Bassett Hospital, Cooperstown, N. Y., benefit from the services that are at the disposal of their physicians to give them modern medical care. Above: The biochemistry laboratory. Below, left: Making a blood analysis. Right, top: Corner of the animal room. Right, below: Ward rounds.



the plans in the first category, from an awareness of the social and economic problems of medical care and from a desire to contribute to the solution of these problems for low-income families. Most of these plans are organized around a prepayment arrangement of some sort.

Like cooperatives and insurance companies they operate on principles of collectivism. Ownership, to be sure, is generally not collective; but among these groups the insurance principle of spreading the cost equally among the individuals of a large group and distributing the benefits only to those upon whom the blows of disease and disability fall is basic. Some derive income only from periodic payments by those eligible for benefits; others, from both the insured and the employer; still others, from the employer alone.

Range of Service Varies

In some cases, but not in all, the base of all the activities of the group is a hospital; dependents may or may not be included; the amounts of the annual payments by subscribers vary among the different plans. The range and extent of medical services provided, *i.e.* domiciliary visits, office calls, hospitalization, maternity care, x-ray tests, laboratory examinations, other diagnostic procedures, medication and mechanical appliances, are far from uniform.

A few details of the medical services provided and the cost to subscribers of four interesting examples of group medicine plans incorporating the prepayment feature are presented in the following paragraphs.

1. Ross-Loos Medical Group, Los Angeles. Started 1929.

Medical Services: For subscribers, domiciliary, clinic and in-hospital care of general practitioners, specialist services, surgery, maternity care and hospitalization in ward up to ninety days per person in any one year are provided. Maternity care, special nursing, dental care, treatment of venereal disease are not included; dependents are accepted for medical care on a reduced fee-for-service basis.

Charges: Subscribers, in groups, $2.50 per month per person; individual subscribers, $3 per month.

Subscribers (1943): 26,142; dependents on a fee-for-service basis, approximately 71,000; total, approximately 97,000.

Staff: Full-time physicians, 90; registered graduate nurses, 88.

Hospital Facilities: The group owns its clinic building but hospitalizes patients in independent voluntary hospitals.

2. Farmers Union Hospital Association, Elk City, Okla. Started 1929.

Medical Services: Complete domiciliary, office and in-hospital care by general practitioners and specialized services are provided, but there are extra charges as follows: domiciliary visits, $1 plus 40 cents per mile one way; surgery, $20 for use of operating room and anesthetic; minor operations, $10; maternity care, $10 for anesthetic and use of operating room; hospitalization, $4 per day (semiprivate) during first year of membership and $2 per day thereafter.

Charges for Membership: Initial membership fee representing one share of stock in the association, $50 (refundable upon termination of membership).

Charges: Subscribers, $12 per year; subscriber and spouse, $18 per year; subscriber, spouse and two or more children, $25 per year. Other dependents, $6 per year per person.

Subscribers: 10,000.

Staff: Full-time physicians, 5; dentists, 2; registered graduate nurses, 2.

Hospital Facilities: The association operates the Community Hospital at Elk City.

3. Group Health Association, Inc., Washington, D. C. Started 1937.

Medical Services: Domiciliary, office, in-hospital care and specialist services are provided with exceptions and extra charges as follows: first domiciliary visit, $1; elective surgery and maternity care during first ten months not included; thereafter, maternity care, $50; hospitalization, organization pays $5 per day per person for forty days in any one year; dental care, drugs, appliances, diagnostic x-rays, radium and deep x-ray therapy and care of chronic illness developed during the first three years of membership are not included.

Charges: Application fee, $2 per person; subscriber, initial membership fee, $10 and $2 per month; spouse or adult dependent, $2 per month; dependent children, $1 per month per child for first three children, no charge for others.

Subscribers (1943): 3471; dependents, 5145.

Staff: Full-time physicians, 8; part-time physicians, 9.

Hospital Facilities: Patients are hospitalized in independent hospitals.

4. Northern Permanente Foundation, Kaiser Co., Inc., Vancouver, Wash. Started 1942.

Medical Services: Domiciliary, office and in-hospital care by general practitioners is provided as are specialist service, surgery, diagnostic dental x-rays; hospitalization (semiprivate or private) for employes, up to 111 days, for dependents, up to thirty days, for any one illness. For maternity care the patient pays $50 plus $25 for hospitalization. Dental care, treatment of alcoholism, drug addiction, venereal disease, pulmonary tuberculosis, nervous disease and pre-existing conditions if in nonacute stage are not included.

Charges: Employe, 50 cents per week; husband or wife of employe, 75 cents per week; dependents, 50 cents per child, $1 for two or more; hence the annual charges for a family of four or more are $117.

Hospital Facilities: The organization owns and operates a 350 bed hospital.

Subscribers (1943): Employes, 30,500; dependents, 3500.

Staff: Full-time physicians, 38; part-time physicians, 2; registered graduate nurses, 165.

The Kaiser Co., Inc., operates similar plans at Oakland and Fontana, Calif.

High Quality Care at Low Cost

These four group medicine plans incorporating prepayment for medical care and salaried physicians offer opportunities to study the possibilities of providing by group medicine arrangements medical care of high quality at low cost to the actual consumers.

The Kaiser plan seems to present the greatest opportunities to achieve the major objectives: (1) all forms of medical care are centralized in a hospital; (2) medical services for

those who are eligible, including dependents, are nearly complete; (3) participation is voluntary; (4) the subscribers, since they alone make contributions, receive the benefits as a right, not as a charity; (5) the individual physician has no financial stake in the individual patient; (6) preventive measures are an integral part of the program; (7) the internal arrangements make possible the kind of integration of library, laboratory and care of patients which modern medicine urgently demands; (8) fee-for-service is eliminated and free choice of physician is restricted.

From the point of view of social significance the Kaiser plan involves a compromise, however, because eligibility is limited to the employes of a single company. Whether such a plan can maintain an intellectually stimulating atmosphere and develop attitudes of critical inquiry, such as one finds in most of the group medicine plans in university groups, time will reveal.

If we could add to a Kaiser hospital a university affiliation, a program of medical research, eligibility of nonindustrial groups and individuals, a continuing internal program of education, we would visualize something close to the ideal group medicine plan.

No Congratulations in Order

Organized medicine and especially the leaders and spokesmen of the American Medical Association cannot be congratulated on their part in developing group medicine plans. The report of the Committee on the Costs of Medical Care based on thorough study of the social and economic problems of medical care advocated the establishment of group medicine plans. Even though the chairman of this committee was a former president of the A.M.A., the report was greeted editorially in the *Journal of the American Medical Association* by the comment that it incited to "socialism, communism and revolution."

From this rather fanatical attitude the spokesmen of the A.M.A. have been forced by the tide of public and medical opinion to retreat. But even in the most recent reports and comments from the A.M.A. a persistent negative orientation, to state it as pleasantly as possible, toward group medicine is all too clearly evident.

In the fact that the most advanced and socially one of the most promising examples of group medicine, the Kaiser plan, is under lay control the medical profession may find a forecast and a warning. If, in the new forms of organization of medical care that are taking shape, the physicians of this country find themselves working under lay control, they need not, in searching for the cause, look beyond the social immaturity of their spokesmen.

Clearly, the quality of medical care is closely related to the kind of organization in which the physician carries on his professional activities. With the increasing tempo of medical progress and the flood of new discoveries, many of them important in the everyday care of sick people, the individual physician practicing independently on a fee-for-service basis is left farther and more hopelessly behind.

The most promising solution is group medicine with arrangements for continuing professional growth, salaried staff, academic affiliation wherever possible, some degree of specialization and the removal of solo practice, with appropriate recognition of past services, to the museum of medical history.

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INTEGRATION IS THE KEYNOTE

—Angrist

IDEAL group practice is more than the combination of several physicians who agree to refer their clientele to one another. This is often only the cooperative bandying of patients, with the patients' interest not the main consideration.

Group medicine ideally should represent the practice of diagnostic, therapeutic and preventive medicine by an integrated group of physicians. This should include general practitioners and qualified specialists in as many of the fields of medicine as the particular or specialized interest of the group may demand, and as determined by the size of the group to be served from the standpoint of expense involved.

The combined group service becomes the unit of service, the unit of charge, the unit for application of our basic ethical and economic tenets in lieu of multiple independent charges by every individual physician without a distinct orientation to the patient's total needs. Group practice can be the total all-out attack against disease, with adequate consideration for the problems of defense and offense.

Hospital Offers Ideal Center

Such group medicine can best operate from a single center that possesses, in addition to physicians, all of the necessary physical facilities and other professional personnel that have become essential for the practice of medicine. This unit is already formulated for us in the modern hospital. The physical facilities should include well-designed office space, with examining rooms and special fixed equipment. Of course, the present out-patient department facilities would have to be altered and additional personnel obtained to render a more efficient appointment schedule. The changes, however, would be relatively minor ones to obtain the benefits of a centralized group of offices for physicians for the care of ambulatory patients. This would correspond to the present office form of private practice but would constitute only a part of the total service.

It would no longer be necessary for each man to possess his own electrocardiograph, diagnostic or therapeutic x-ray equipment or to invest in rapidly-changing physical therapy or other special equipment. The obvious economy incident to sharing the use of clerical, nursing and technical personnel calls for no further discussion. The use of expensive equipment by a group as a whole represents a sharing of expense and an increase of efficiency and assures adequate up-to-date facilities.

The hospital is the ideal organized professional unit for group practice activities. The saving in avoiding duplication and the proper integration of personnel has been stressed by others. I would stress the stimulation of group presentations, ward visits, rounds and conferences.

Hospital organization lends itself to bed and ambulatory medical practice most efficiently, with full consideration for its diagnostic, preventive and therapeutic phases. It makes practicable the necessary follow-up home care, visits by physicians, nursing personnel and social service agencies. All personnel can be easily rotated and radiate from such a central unit. All medical needs can then be met in an efficient and less expensive manner.

This item of expense is most important if the efforts of group practice are to be brought to the community as a whole. The hospital organization should be integrated with the ambulatory office units and the facilities of both functions should be available to members of the group for the care of their patients. An uninterrupted, personalized doctor-patient relationship could thus be instituted.

The advantages of controlled hours, regularity of rest, vacation and, above all, the security that follows from the broader base of group activity should be material stimulants to physicians for group effort. Group practice can more equitably match the remuneration of the individual physician with the true value of his service as rendered, for his efforts are judged better by his colleagues, who are in a position to know, than they are by the uninformed patient.

Eliminates Unethical Practices

Group practice eliminates many abuses now existing in medical practice that have been prompted by the existence of the very need for some form of group medicine. Fee-splitting represents an unethical, underhand, inefficient and unregulated attempt at group practice. Group practice emancipates the patient from the status of a thing possessed and promises resurrection of the general practitioner and the proper orientation of the present hospital-employed specialists, such as pathologist and roentgenologist, to the patient, the hospital and medical service as a whole.

Group medicine can flourish independently of hospital organization by the expedient of using hospital facilities by individual members of the group or by group contract. Nevertheless, the hospital is the most important integrative instrument for assuring the success of group practice. This can best be seen in the application of the hospital unit to preventive medicine. The individual physician is loath to become interested in preventive medicine because it requires routine humdrum chores. The hospital, with its available additional professional personnel, promises to free him from the most obnoxious features of this most important phase of medical practice. The hospital unit is the ideal health center to coordinate preventive and

curative medicine in all of its various aspects.

The organization of the medical board of the modern hospital can serve well as the basis for the organization of the group as a whole. The operation of the various services in the hospital can be carried over into the ambulatory work if the group is large enough for such segregation of functions throughout. The number and type of specialists would vary with the type of practice that would become the main interest and the source of reputation of the group.

A group specializing in neurosurgery or chest surgery would need a setup of personnel and equipment different from that of the ordinary diagnostic group. A mental hygiene group or metabolic disease group would require a particular setup of personnel to meet its own needs. In larger centers such specialization of different groups is quite possible, and its advantage has been attested by experience in the armed forces.

Smaller communities could afford only a smaller group, to include surgeon or surgeons, gynecologist, obstetrician, oto-laryngologist, internist and others depending upon the size of the total group of recipients of the service. It would seem that referrals to and by groups of specialized interest could be fostered just as well as can individual referrals.

Give Medical Board Authority

Some adjustments in the organization of the hospital are necessary if this unit is to become adapted to the care of patients in group medicine. It would seem advisable that the medical board be given complete authority over all medical matters and greater authority than it has at present concerning major economic policies and the remaining personnel of the organization.

This is no more than fair if the source of remuneration is to depend upon an insurance scheme in which the physicians themselves are basically the co-insurers. By this I mean that the monies obtained for services rendered will be distributed to physicians on the basis of a fee for service, the exact amount of this unit fee to depend upon the total service rendered.

Unless a minimum is guaranteed for the fees for service, then one of the main sources of capital for the group is, fundamentally, the skill and good will of the individual physicians. If the other members of the organization, including administrative, nursing and technical personnel, are to receive *set* guaranteed salaries, but the physicians themselves are to depend upon sums of money based on contingencies, then it is only fair that the physicians should have greater authority over the economic aspect of the organization.

Have Recipients Represented

It would seem fair that a large proportion, if not a majority, of the members of the board of directors, or of an empowered conference committee, should be physicians who may be elected by the medical board of the hospital and all participating physicians of the group. It would also seem wise to have on the board of directors representation from the recipients of the service. In an insurance scheme this would be members elected by the subscribers or large groups of insured. It would also seem wise to have on the board of trustees representation from the nursing personnel and, in large organizations, the social service group.

Of course, if the source of remuneration is to depend upon taxation or assured philanthropy and if physicians themselves are to be guaranteed set salaries which are to meet minimum standards, then the present organization of the hospital unit with some representation from the medical board on the board of directors or a conference committee would seem to offer the simplest form of adjustment. The insurance law in many states, and particularly in New York State, places the responsibility for the financial policies in any nonprofit medical expense insurance scheme upon the board of directors and not upon the medical board.

It would seem imperative, then, that whenever doctors are contributing to the risk of their own income they should be adequately represented on this board of trustees. Only by this means can they assure the patient of medical personnel that is going to be satisfied and contented and feel that it can control its own conditions of work.

No scheme can ultimately succeed from the standpoint of the adequate personalized care of the patient unless the participating physicians do obtain that economic security and opportunity to do good work which are the fundamental advantages of group medicine. Contented cows give more and better milk. The milk of human kindness plays no small part in medical service.

Another adjustment seems advisable. To compensate for the loss of some independence and individual control over their destinies, all physicians, particularly the general practitioners, should have adequate representation on the medical board. This may take the form of a junior staff elective representation. By this means or some other, all sources of effort and service functions of the group can have adequate representation and find expression for their individual and combined interests.

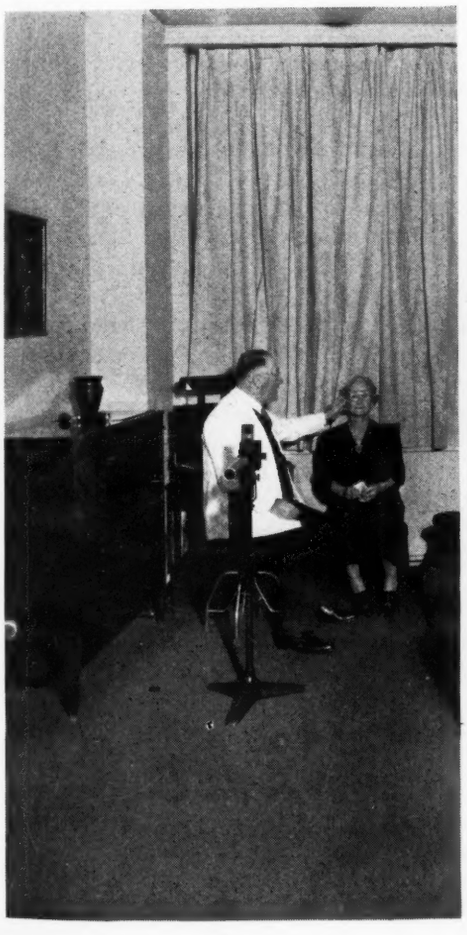
Personal Interest Assured

By this democratic process they obtain the constructive promise of personally interested, satisfied workers who can be critical and initiate beneficial changes in the program. Without such machinery for representation, they have only the authoritative stifling rule from above and the physician then loses his professional stature and is reduced to a mere hired agent. This must affect the quality of medical care sooner or later.

By such adaptations in hospital organization, one can avoid entirely the charges of the interjection of a third party into the doctor-patient relationship and the impersonal practice of medicine by the hospital.

The true importance of trained medical and hospital administrators should be obvious for the promotion of an integrated, efficient group effort and elimination of bureaucracy. The parallel evolution of group practice for dispensing medical service, on one hand, and group insurance to equalize the cost, on the other, gives added stature to the problem of scientific administration.

Patients awaiting appointments with their physicians find upholstered chairs and divans, well-placed lights and, in general, a comfortable and reassuring atmosphere in the clinic with which the author, Mr. Stasel, is connected.



Above: Exterior view of the building in which the Nicollet Clinic is housed. The clinic is located in one of the business sections of Minneapolis and is readily accessible to the patients. Left: An ophthalmologist tests the vision of one of the clinic patients. In a clinic such as this the organization must be balanced professionally as well as economically if it is to succeed and to grow. There must be a policy of perpetuation based primarily upon succession or promotion, coupled with proper rewards for staff efficiency.

FUNDAMENTAL PROBLEMS

—Stasel

THE organization of private group clinics had its greatest impetus following World War I, for it was out of the experience gained in military service that medical men developed the idea of working together in the practice of medicine in civil life.

The types of organization that clinics follow are for the most part either sole ownership or partnerships. The latter seem to be the more prevalent. The most flexible system for a group of doctors to follow in setting up a clinic is a dual organization: a corporation organized on a stock basis or as a foundation on a non-stock basis to own building and equipment, the ownership to include all of the doctors in the clinic or only part of them as may be desired, the financial interest to be equal or unequal as they may determine. The professional practice, however, because of the ethics of the profession and because of the legal requirements usually is in the form of a co-partnership. This, in turn, can have its variances.

Goals of Group Medicine

The first fundamental of a group of doctors working together in the practice of medicine is that it must have clearly defined ideals. What are these ideals? Perhaps they can be summarized as follows:

1. To unite their efforts for the most effectual practice of medicine and surgery.
2. To establish, maintain and operate clinical, pathological, medical, surgical, research and other laboratories.
3. To render gratuitous service to the indigent and distressed.
4. To provide instruction and opportunity for research in all branches of medicine and surgery.

This idea perhaps may be summarized in a few words: "the best medical service possible for the public at a cost within the ability of the average person to meet."

The first qualification for membership in such a clinic should, without a doubt, be that of compatibility. Working together in a team to achieve the ideal set forth is essential to the success of the clinic.

Other requisites that must be closely adhered to are common sense and technical skill. These go almost without saying but are mentioned because they are sometimes overlooked.

There must be competent counsel and the desire to pass on to the public the benefits derived from this counsel through staff conferences and consultations freely given so that the patient will receive the ultimate in medical service. One reason for the success of many of our clinics today is that the members thereof, whenever a difficult or obscure case comes up, are willing collectively to put forth extra effort to solve the problem involved.

Pooled resources as to investment and pooled resources of personalities in the various specialties, properly balanced for the formation of a clinic in group practice, are economically sound.

Perhaps the greatest problem facing a group clinic during and after its organization is that of discipline and the determination of a proper basis for a division of net income. Someone has said that "all the doctrine of equal rights can hope to accomplish is that the man who is most deserving shall be placed where he should be until the last page of the last volume is written in the Book of Years and merit alone rules the earth." This principle must be recognized and put into effect if a clinic group is to continue to function and grow. However, not all of the reward need be monetary. There are other compensations as well.

The clinic organization should be balanced professionally and economically. In this connection there must be a policy of perpetuation based primarily upon promotion in order to bring about, insofar as possible, that ideal organization in which there may be found complete harmony and compatibility.

With the right personalities who are completely compatible and with an organization with proper ideals perpetuated through a policy of succession or promotion, coupled with proper rewards for efficiency, the group practice of medicine not only should succeed but should grow as well, for the opportunity is here for those who will make use of it.

Group practice is here to stay. Today the evidence of the stability of this form of medical service is demonstrated in the continued growth of clinics throughout the Midwest, Southwest and West. The public is becoming more cognizant of this trend.

These organizations may be in urban areas, in rural areas or may serve a particular section of industry. They can be a group of general practitioners with one or two specialists, as is usually the case in rural areas, or they can be a group of specialists cooperating in urban areas. The type of medical personnel depends a great deal upon the demands of the community served.

More General Practice Needed

With the advent of more prepaid medicine, however, the need for a general practice department in those clinics that are comprised of specialists is obvious. This is going to be necessary in order to render a prompt and adequate medical service and also to conserve the time of the specialist.

The health structure of the nation is in the hands of the medical profession. The return of many young physicians from military service, many with no practice to which to return and having been trained to work together with adequate laboratory facilities at hand, should have a marked effect on medical leadership.

In their medical experience in military service these men have learned to work together. Many of them will seek affiliation with medical groups already organized. Others will want to get together in their own communities to organize clinics or group practice of medicine because it means to them a high type of medical service on an economic basis that is dignified and ethical.

IT WORKS AT PERMANENTE

—Garfield

TWELVE years ago in the desert of Southern California a group of contractors was engaged in constructing an aqueduct to carry water 300 miles from the Colorado River to Los Angeles. In that expanse of desert a medical and hospital service had to be created. It seemed like a relatively simple job; we borrowed funds, built a small hospital, staffed it and opened for service.

Totally ignorant of medical economics, we had tackled the job of providing medical and hospital care to a group of workers without benefit of any crutches; there were no rich people to help pay for these poor, there was no charity or philanthropy to help pay for the hospitals, there wasn't even a county hospital to which we could send cases. As might be expected we ran into considerable trouble.

There were two possible sources of income: income from insurance carriers and income from the workers themselves.

Not Much Income Here

The first source proved disappointing. When bills were sent the insurance carriers, more often than not they were returned heavily discounted with notations that we had overtreated the cases, or severe accident cases would be moved to Los Angeles where the insurance carriers had their own doctors and hospital arrangements permitting better control of costs.

The second source of our income proved equally disappointing. Not that there was any lack of illness and accidents occurring off the job, but these workers could not pay for their medical bills.

After eight months of struggling with this situation our financial position became rather precarious. Pay rolls couldn't be met, creditors were unhappy and becoming unpleasant and it became evident that our hospital would have to be closed. By

that time, however, we had become well acquainted with the contractors. They liked our service. They had a moral obligation to take care of their workers on the desert, and we had taken that obligation off their hands. They didn't want us to close up so they called their insurance carriers into a conference and developed a plan for prepaid industrial medical care.

The insurance carriers estimated that 30 cents of every dollar they collected as premium would normally go for medical and hospital care. They agreed to give us one half of that amount, or 15 per cent. For that amount we would do the entire medical job on the desert. They would reserve the other 15 per cent for cases they had to take to Los Angeles.

This arrangement worked beautifully. From that time on there was no more financial trouble. There was a definite weekly income and expenses could be budgeted accordingly. Pay rolls could be met, creditors were paid off and we were able to provide these workers with all the medical and hospital care they needed for industrial accidents.

Under this arrangement we got the same amount of income whether the workers were injured or not. Obviously, we were better off if they remained unhurt. So we began doing safety engineering, tracing accidents to the source, eliminating hazards and avoiding recurrences. Under the old arrangement we would have been putting ourselves out of business.

There was a change in the attitude of the insurance companies. They had been telling us how to treat our patients and how many times to treat them. Once this new arrangement was in effect they no longer cared how many times we treated these patients as long as we did a good job. From that time on the only cases moved to Los Angeles were those we asked them to move. Medical care was put back in our hands, where it belonged.

Having solved our compensation problem we next turned our attention to the noncompensation problem. We started a prepaid plan for nonindustrial medical care. The employers helped us put across a 95 per cent voluntary sign-up, and that worked beautifully too. We had no more trouble trying to collect bills.

Ended With Good Record

Two more hospitals were built; additional physicians and nurses were employed, and better equipment was purchased. We ended five years in the desert having given these workers a large amount of good medical care, having remunerated our physicians, nurses and other service personnel very well, having built and completely paid for $150,000 worth of facilities and equipment and having learned a lesson in medical care which has been the basis of our operations ever since at Coulee Dam and in the shipyards.

Hampered by shortages in facilities, equipment and personnel our service has had many shortcomings, but in spite of these shortcomings we take a great amount of pride in knowing we have given those workers more medical and hospital care than is received by any other group of workers in this country outside the armed services and we have created the finest facilities in the country.

The principles of our plan that we think are important are four. First is prepayment. Prepayment, in our experience, is the only way people of moderate means can pay for the increased cost of medical care today. This is the old, but sound, principle of the well paying for the sick; the

From an address to a county medical society.

houses that don't burn down pay for those that do.

The thing to remember about prepayment is that it brings the patient to the doctor earlier in his illness and more often, which is one of the most important effects of a health plan because it permits the practice of true preventive medicine. Any plan that sets a barrier between the patient and the doctor by eliminating the first two or three visits, by covering the patient for hospital or surgical care only or by limiting his coverage in other ways defeats its purpose and is not good.

There is another thing to remember about prepayment. Prepayment itself is not sufficient. There must be a reorganization of medical care to produce some economy in medical service so that the prepaid funds can do the necessary job. That organization is referred to in the next two principles.

Principle two is group practice. Medical knowledge has become so vast that no one man can cover the entire field. As a result, specialties have developed; however, each specialty has gone off as an individual unit. Obviously, what is necessary is that all these specialties, all these individual units which together comprise one medical unit of service, be brought together as a group under one roof.

High Quality at Low Cost

Such a group arrangement or practice results in many advantages and in many economies. The chief economy is that of quality medical care. There is saving in transportation and saving in duplication of facilities, personnel and equipment. There are the advantages of ease of consultation and stimulation of working with well-trained men in the various specialties and making maximum use of young, well-trained physicians in a group, up to the limit of their capabilities under supervision. It has always seemed a paradox that in universities that teach us medicine we learn under the highest type of group practice but when we leave the university, we revert to the old type of individual private practice.

The third principle is adequate facilities. By adequate facilities we mean bringing the doctor's office, laboratory, x-ray facilities and hospital, the doctor's workshop all together under one roof. Obviously, such an arrangement of facilities results in economies, saving of transportation, saving in duplication of equipment, facilities and personnel, but the chief advantage is the great accessibility between the doctor and his workshop and his sickest patients. A physician working in a group in such adequate facilities does a great deal more work in less time. Such an arrangement permits a doctor to have a more normal life, permits him to study, to do investigative work and to devote some time to his family.

The fourth principle is a new economy of medicine. With the new discoveries in medicine and those yet to come, medical care for sickness is a diminishing economy. A peculiar situation has developed in medicine. Physicians and hospitals are dedicated to the proposition of keeping the people well and healthy yet they derive their income out of sickness. On the other hand, the people don't want to get sick; they want to remain well. Medical care for sickness is a necessity of life but it is an unwanted necessity. The wanted necessity of life is medical care for health.

The problem becomes essentially this: how to keep the people well and healthy and at the same time preserve the medical and hospital organization which must do that job but which under our present system of medical care derives its income out of sickness.

The answer is simple. When the prepaid funds go directly to the medical and hospital organization doing the job not as a fee for each sickness but as a total sum, a situation is produced whereby the medical and hospital organization is better off if the people remain well. It, obviously, then has more funds for remuneration. It has more funds for teaching, training, research, building of new facilities and everything that it wants to do.

Various people have stated that the most expensive thing in the hospital is an empty bed. They are not referring to the Permanente Foundation hospitals. The most expensive thing in our hospitals is a filled bed. This new economy is geared to the preventive medicine of the future. It puts the patient, the doctor, the hospital, the employer and the insurance company all on the same side of the ledger.

Use these four principles, prepayment, group practice, adequate facilities and new economy in medicine, as criteria to evaluate existing plans and proposed plans. Most of the medical society plans have prepayment and nothing else. They are, therefore, expensive and wasteful; the majority of them cannot do the complete job of medical care without putting in barriers and limitations.

The Mayo Clinic has two of those principles—group practice and adequate facilities. It hasn't prepayment and therefore reaches only pay patients; it hasn't new economy and therefore is not geared to preventive medicine of the future.

Operate With Prewar Income

To prove how effective these four principles are in the Richmond and Oakland area we have taken care of the medical needs of from 60,000 to 90,000 workers. They are not a selected group of men. We have no preemployment examinations as the union will not permit it. They are the 4-F's, the aged, the proverbial pathological museum. Incidentally, they are the men who have done an excellent job of building ships. In spite of the tremendous medical load, we have operated with prewar income, the same 50 cents a week that we had at Coulee Dam and the same industrial income.

We have given those people the most comprehensive plan we have ever attempted. We have remunerated our physicians and other service personnel well above the average.

We have built and completely paid for our original facilities, almost one million dollars in two and one half years, and we have provided $100,000 for research because it is our conviction that a medical plan worthy of perpetuation must be more than a commercial enterprise. It must be creative—create facilities, teach, train and do research so as to stimulate the quality of medical care and con-

tribute to medical care of the future.

The arguments against our plan that I usually hear are as follows:

Skeptics usually say this is a wartime job. It wouldn't work in normal times. We hasten to inform them that it was done in prewar days and it worked as well then as now. Another argument is that we are working with a large group of people, which makes it possible. We then point out we had 5000 workers at Coulee Dam and down on the desert some of the groups were less than a thousand. We still gave them good medical care.

Then they ask, "How would your plan take care of unemployment?" Our plan takes care of illnesses for a year after termination of employment. Any plan could take care of unemployment by adding a surcharge of 5 cents per week for a reserve.

Doctors usually say that medicine in our plan is being dominated by an industrialist. Mr. Kaiser's domination amounts to this: He guaranteed the loan made by the banks with which we built our facilities. Aside from that, his only domination has been to urge us to do a better and better job. I think medicine needs more of that type of domination.

Permanente Foundation is a charitable trust. Any funds that accumulate to the foundation must be used for such purposes as creation of facilities, teaching, training, research, rehabilitation of physicians returning from the armed services. Not one penny of our income can go to Mr. Kaiser.

Is Free Choice So Important?

Another argument of doctors is that our plan interferes with free choice of the doctor. Some question whether the patient can wisely choose his physician. Some question whether free choice is good for the physician who should advance on merit. Regardless of this, with specialties developing in medicine, free choice is becoming of less and less importance.

Most physicians today are operating in groups. When a patient comes in to see a medical man and he has a surgical condition, the internist will refer him to one of the surgeons with whom he works because he believes he is a good surgeon, and if the patient goes to the surgeon and has a medical condition he will be referred to that internist if he is a good medical man.

In other words, most physicians are operating in group medicine, though unofficially and inefficiently. They haven't gathered together under one roof. They are duplicating facilities, personnel and equipment, but they still are operating as a group. The patient who comes to a doctor freely chooses a group; that is the free choice that actually exists today. That is the free choice of

tomorrow. The man who goes to Mayo Clinic chooses that group and the patient who voluntarily joins our plan is freely choosing our group.

Another argument is that doctors do not like to work for a salary. I agree with that 100 per cent. I should dislike working for some layman who was making money out of my services. I should dislike working for another doctor who was making money out of my services. Our physicians work for nobody but themselves. There is no money being made by anybody but themselves and the other service personnel. All our funds go to service personnel, to creation of facilities, to teaching and training—all things they want to do.

Another objection listed by the medical profession is that there is no incentive to a doctor working under such a plan. I think the chief incentive of a doctor is not the making of money. Once assured of a good income, his greatest incentive is the knowledge that he is doing a good medical job and that he is contributing to medicine, developing in medicine and has the respect of his fellow physicians.

The last argument I can think of is that we are offering socialized medicine. Obviously, we are not government medicine. Our physicians operate their own medical service as a group. It is just as much of a true private enterprise as private practice is. In fact, it is more so in this respect: our doctors not only operate their own medical service, they operate their own hospital, which is something that private practice hasn't yet achieved.

Now it is important to make clear that our thoughts in these matters are impersonal. We are not in the medical service business. The motive behind all the medical care we have provided has always been the absence of medical care in the areas where we have had construction jobs. Mr. Kaiser has no ambition in the medical field. He thinks that is the physician's job.

The physician is the one who is qualified to do it and should do it. Most doctors know that the government is anxious to take over medical care in this country. When I say the government I don't mean the President or other key men in Washington. Most of the pressure comes from men farther down the line in government circles and to give them their due credit the reason for this is not always personal ambition. It is because they sincerely and earnestly believe that the medical profession cannot and will not do the job.

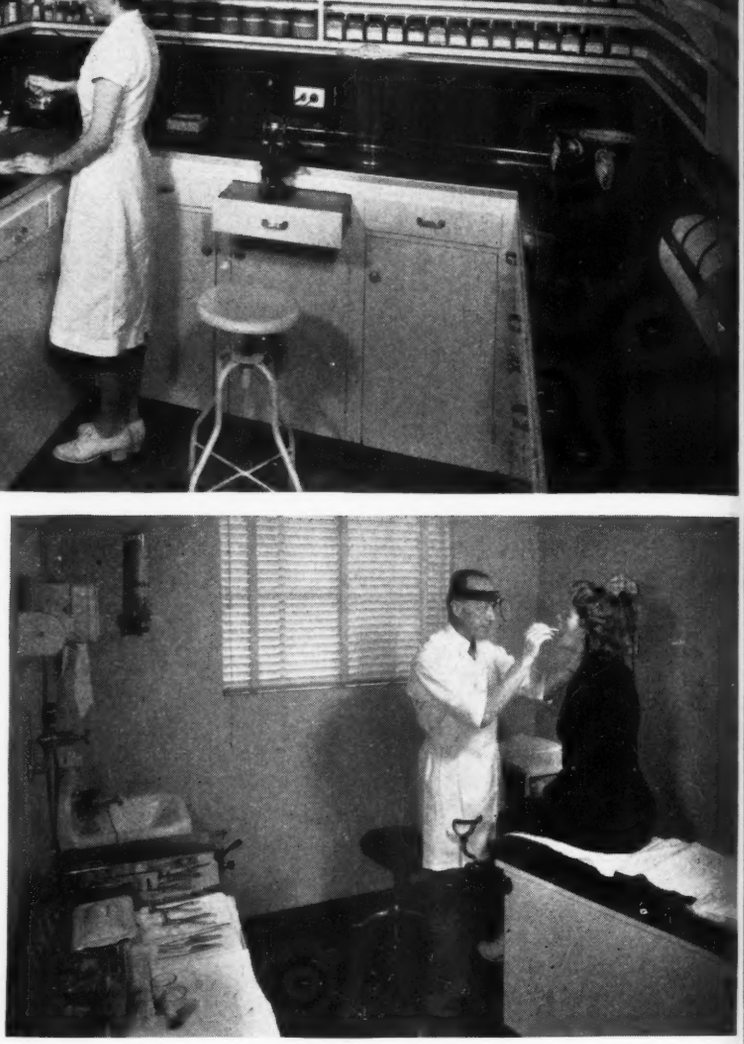
Job Must Be Complete

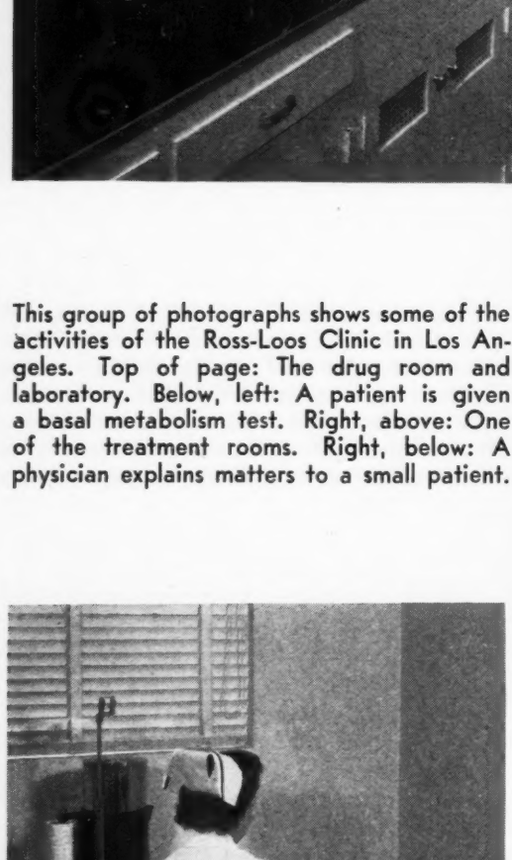
It doesn't do any good for the physician to sit back and talk about the swell job he has done. He has done a swell job but that won't help. It doesn't do any good to build a wall around the medical profession and to preserve the *status quo*. It doesn't do any good to anesthetize oneself with indemnity plans, incomplete plans and partial coverage plans. If the medical profession leaves any part of the job undone, it is leaving a weakness that is going to make it vulnerable and it is going to be attacked.

The plan outlined, which gives so much care at a cost the people can so easily pay, provides good remuneration for the physician and other service personnel; it needs no subsidy or charity and even provides funds for teaching, training and research, and it does all these things better if the people remain well.

I sincerely believe that if the medical profession would accept these principles, if it would do the job, it could preserve private enterprise in medicine. It would create such a brilliant advance in quality and spread of medical care that no other plan in this country or any country could approach it. It could make government medicine unnecessary.

This group of photographs shows some of the activities of the Ross-Loos Clinic in Los Angeles. Top of page: The drug room and laboratory. Below, left: A patient is given a basal metabolism test. Right, above: One of the treatment rooms. Right, below: A physician explains matters to a small patient.





IN RURAL AREAS

—Loos

A KINDLY Catholic priest, solicitous for the temporal as well as the spiritual welfare of his flock, called upon me one day for advice regarding the medical care of his parishioners. His parish was situated in the foothills of the Cascades in central Oregon. He had been attempting for years, unsuccessfully, to get the four physicians in his area to cooperate to serve his people better. Even the offer to construct a hospital for them had failed to get results.

A hard worked old country doctor from the fringe of the Ozarks, not far from Joplin, Mo., consulted me concerning the problem of getting two new doctors to move into his town. His object was twofold: his desire to serve his people better and to run out of business two competitors whom he branded as "rascals."

A welfare worker, an inspired young woman who was devoting her life to the betterment of the scattered families in the Sand Hills of Nebraska, came to see me. She had made intelligent studies and her stories of the unwillingness of the country doctors in that area to cooperate or to do anything to change conditions for the better had brought her to consult me. She requested me to go back with her and try to do some organizational work.

They Come From Everywhere

From east and west, from north and south, doctors and laymen continually come to see me in attempts to solve the great problem of better care for rural America. The Associated Women of the American Farm Bureau Federation have for years kept the medical care problem high on the list of their agenda. Countless times I have been consulted by their study groups and on many occasions have addressed their gatherings on the subject.

Fully aware of my inadequacy as a counsel in these matters, and realizing that in consulting me these people are clutching at straws as they know nowhere else to go, I naturally have become much interested in this problem. The more I study it, the more convinced I am that the best answer is group medical practice. In investigating the deplorable situation existing in many country districts regarding the practice of medicine, it is wise to analyze the factors other than medicine that pertain to this situation.

Over the years there has been an increasing emigration of rural residents to the cities. This inclination has continued even in the face of the pleasanter living conditions in the country districts. Paradoxically, many a city dweller longs to live in the country. He dreams of the time to come when he can desert the populous districts and retire into the country. But the old fetish of "home town boy makes good in city" still holds its glamour.

Many young graduates in medicine settle in the rural areas with the avowed intention of staying there only long enough to make the money that will enable them to move into the city. Many established country doctors have done the same with the result that not all, but many, of the rural districts are served medically by older men who were not able to get away. This is decidedly wrong.

The general modernization of country districts, which is proceeding at a rapid pace, certainly should make the country a pleasanter place in which to dwell. Modern roads, good cheap automobiles, electricity, better country stores, motion pictures, radio and the approach of television all have improved rural life. Country practice of medicine could be a pleasant and lucrative experience but for one factor, namely, the doctor still lives a life of professional isolation.

The professional life of a country physician could be made much happier if he would radically alter the old system of the horse-and-buggy doctor. This could be done by group practice. The advantages to the physician under such a system would be great, but the advantages to the population that he serves would be much greater.

Competition Breeds Quarrels

In many instances doctors practicing in the same country town do not get along well together. This results almost entirely from competition. When the doctor walking down the street sees an old patient approach wearing a clean and professional looking bandage that he did not apply, he immediately begins to think of the many kindnesses he has done for this man and his family over the years; his resentment rises and he develops a grudge against another doctor in the community for having lured his old patient away.

Bad blood starts, and soon the doctors in the small town ignore one another and refuse to consult. If this competitive barrier could be removed there is no reason why these doctors could not get along quite well together.

The country doctor feels obligated to his patients to the extent that he can never get away. There is always a hang-over of patients whom he does not like to leave. Not only can he not absent himself for recreational purposes, but he cannot go to medical gatherings or take refresher courses. Even though he is astute and reads professional books and magazines, he cannot keep up with

the pace of progressing medicine without the personal contact of outside sources. Give him a chance to get away once in a while and to go to centers of learning and he will be a better doctor.

Often, the doctor has his office in his home. This places him in a position of being continuously on duty. It is unfair to his wife and his family that the privacy of his home should be so violated. He has no time to himself. People break in on his privacy at mealtime, in the evening and at all odd hours. He never can relax.

Consultation Would Be Welcome

The country doctor would like to have more equipment than he usually possesses. This equipment is expensive for a man practicing alone and with limited income. He would like to be able to make cardiograms; he would like to do fluoroscopies; he would like to make basal metabolism determinations; he would like to have the equipment and time to do blood chemistries and other laboratory work.

The country doctor would welcome the chance of consultation on his problem cases or on cases that do not seem to be progressing satisfactorily. It is pleasant and confidence inspiring to be able to discuss even commonplace cases with a colleague. This he is seldom able to do.

In too many areas no hospitals are available. The doctor dreads home deliveries; his office is not well equipped for such simple things as tonsillectomies; if he sends his patient away for hospitalization he loses the case and not only sacrifices a fee but does not have the satisfaction of witnessing the progress of his patient's condition.

All these and many more disadvantages could be eliminated by group practice. How many doctors does it take to make a group? Any number over one would be a start. If two or three or four doctors practicing in the same community could get together and pool their resources, many advantages would accrue to each.

Needed equipment is more feasible when the group is pooling its money. One x-ray unit would serve a group, whereas if these doctors were practicing separately, it would take as many x-ray units as there are doctors, a needless extravagance. One main line telephone, one x-ray unit, one microscope, one basal metabolism outfit, one cardiograph, one receptionist who could keep books and attend to front office duties, one waiting room and one

laboratory technician would be sufficient for a group. How much greater the efficiency would be!

There would not exist the barrier of competition, as all patients in the community would be the patients of the group. The office, naturally, could not be at the residence of any one doctor. This divorce would undoubtedly be welcomed by the doctors' families. By this agglutination, stated periods of time off could be arranged.

There are always certain special skills that one general practitioner performs more successfully than do the others. After a period of time there would be a natural gravitation to the doctor who preferred to handle certain conditions, and a partial specialization would result. This would add greatly to the contentment of the medical men and certainly to the efficiency of the work being done upon the patient.

The doctors could alternate in attending medical meetings, and at least once in two years each one could take time off for a refresher course. When the group became well established and streamlined in its operations, the advantages in obtaining a hospital, even a small one, would become apparent. With all of the doctors in the community in one group, a small hospital would not be out of their reach. When this has been accomplished, many cases that were once sent away could be handled efficiently at home.

As to the *modus operandi* of establishing the financial structure of this new group, that would depend entirely upon local conditions. A set of rules that would apply in the plains of Iowa would not fit in one of the suburbs of Bangor, Me. If, in the formation of this group, one doctor should have a substantially larger practice than the others, naturally he should benefit more than those who are bringing fewer patients to the group.

Should an older doctor decide to form a group by importing one or more medical men to his community, it would be wise for him to obtain men nearer his own age. A young man who has learned the newer technics feels equal, if not superior, to the older man, yet the older man is patronizing in his attitude, feels that his experience is important and is likely to give the drudgery work to the younger man, who usually takes it but doesn't like it.

Many of our great doctors have developed in small towns. Witness the brothers Mayo and others too numerous to mention. The medical material is there; it needs development and facilities. If there is one thing more than anything else that will raise country practice in quality to that prevailing in the cities it would be the formation of medical groups. Give the young medical graduate the opportunity of having proper facilities with a proper income and medical camaraderie, and we shall find country practice developing in a way we have never seen before.

The advantages to the patient are innumerable. The difficult work that is part of the lot of the country practitioner, such as distant calls and irregularity of office visits, can be shared and thus cut down to a large extent those unpleasant parts of country practice that make life for the country doctor so hard.

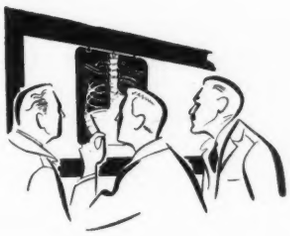
Business-Like Methods Respected

Every group must be run on a business-like basis; when business methods are introduced the patients soon sense it and respect for such measures will be productive of a better income and better collections. Even the introduction of a cash register is not bad psychology and will be tolerated in a group where it would cause offense in a single doctor's office.

In my opinion there are more advantages to group medical practice in a rural area than there are in the urban, and the formation of these groups should receive the hearty cooperation of the lay public that is to be served.

CHANGING ECONOMICS

— Curtin



GROUP MEDICINE has been frowned upon by the organized medical societies, not because it is not a good type of practice but because it presents a different picture. Groups are much more difficult to subjugate and handle. They think and act for themselves when necessary. They are organized.

The profession as a whole is well organized and managed but not by the profession as a whole. This management is principally confined to the specialist groups. Specialists as a rule are well organized and better paid and have time to enter into the so-called political side of medicine. I do not wish to infer that specialists are overpaid but general practitioners are woefully underpaid.

Financial Boon to Physicians

The medical profession as a body or as a whole has been poorly paid up to date when one compares it to business and industry. Group practice well organized and properly functioning is a boon to the general practitioner financially and in many other ways. It is not the regimentation of medical men but wholehearted cooperation of all branches of medicine rendering care.

Group practice does not eliminate the free choice of physician. This is but a time-worn argument. If individuals or groups of individuals in voluntary prepayment budgeted medicine choose a certain group of physicians to treat them, they are exercising free choice to the fullest degree. They can exercise further free choice within the physician group. Patients soon recognize the advantages. They are not continually sent from one individual to another or shunted about from one office building to another. This is unnecessary in group practice.

Patients using this type of service, especially in the prepayment plans, know they have definite rights and privileges and these are respected. They know further that the medical group has rules and regulations and they are in force. Within a short time the doctors and the patients form a harmonious group. The patients know there are no financial barriers and that medical aid and consultations are theirs when necessary or when asked for.

It is surprising how few patients abuse their privileges. As an example, in our group there is no charge for house calls, not even for the first one, and the ratio of such calls is much less, at least 50 per cent, than in the so-called fee-for-service or private practice. The patients see the opportunities of this type of practice in the office and they take advantage of it. It saves them time and the medical men much effort.

A group engaged in prepayment medicine does not have to limit itself merely to budgeted patients. Fee-for-service practice, consultations, industrial medicine, insurance practice can all be carried out in a scientific and democratic manner. All these patients come to one office and no one is labeled. They are free citizens intermingling and no one knows how the other is paying for his service; no one seems to care. The patient under the budgeted plan merely presents his pass book for identification.

They Are Free Individuals

Physicians engaged in group practice are not regimented and are not to be considered merely cogs in a wheel. They are free thinking individuals who progress according to their abilities and the responsibilities they are willing to assume. They have advantages of close-knit association. If they do not fit into the picture harmoniously, they can leave.

These doctors are on their toes most of the time and the physician who does not work industriously and harmoniously in a group would be the same type of individual practicing alone. They seek frequent consultations within the group and the doctors know that they can, if necessary, go outside of the group for further medical assistance.

There is the advantage of regular hours. The younger men are on night call and they know the exact time. They are not called any other night unless in emergencies. They have a half day to themselves in the mid-portion of the week. All the physicians and surgeons, except those on call, are free to enjoy themselves as they see fit from Saturday noon to Monday morning. Heads of departments must answer emergency calls. If there are more than two so classified, they may divide the responsibility. We must never forget that the sick individuals have to have care regardless of our pleasures.

Physicians in group practice have definite vacations with pay, time off for study and postgraduate work. Another advantage is the holding of regular meetings for the interchange of ideas, professional and otherwise.

Retirement Plan Is Possible

Our group is still in its infancy and many improvements and adjustments will have to be made. It is quite possible, over a long period of time, to develop plans for retirement. There is no reason why such a program cannot be instituted.

We do not say that group practice is better or the best but all of us in our group are agreed that we do better work as a group than we did as individuals.

We believe that group practice lends itself ideally to budgeted medicine. We find that the longer budget patients are with us the easier they are to handle and the pleasanter is the association.

The perfect setup is a group operating in a hospital all as a unit, the hospital owning the property and the group or clinic renting quarters from it. The monies of each are separate but the management is essentially the same. For this setup it is necessary to have the right man at the head not only of the clinic but of the hospital.

This ideal group would embrace all types of service: office, home, hos-

pital, nursing, home supervision, welfare and education, with particular stress on preventive medicine as this is an absolute essential in group practice, especially the budgeted type. We must keep trying, as we learn by trial and error.

Medical men are always spoken of as individualists, highly competitive and with little or no inclination to cooperate, and therefore they do not think that this type of practice will work out. Time only will tell. Go back a few years to the advent of the Workmen's Compensation laws. Employers and employes, together with doctors and all allied professions, fought bitterly against them but all to no avail. And what is the answer today? No one opposes the compensation insurance practice unless he is a reactionary fool or mentally deficient.

However, both the group practice and individual fee-for-service practice medical men must wake up and get going. We must stop saying that we medical men and we only shall say how medical service shall be given and paid for. The people who pay for the medical care in all probability will have something to say about it. It would be rather a serious situation if the fire and police departments should make the statement that they and they alone shall handle all problems that come under their jurisdiction and the taxpayers have nothing to say, not even as to salary.

Worthwhile changes in medical economics must be offered and let us hope that the medical body as a whole will take the lead. If we do not, laws will be passed. We will not be in control of the situation and we may well witness the spectacle of the medical profession, which has always held its head so high, being dragged through the muck and the mire of political expediency. Let us remove our halo before we become incurable victims of self-inflicted medical headaches.

IN THE HOSPITAL—*Pastore*

A TENDENCY exists to interpret group practice as a new or different type of medical care. Actually, it is an organizational method by which medical services are made available to patients. The organization can be "tailor-made" to fit any situation.

During the last year I have had the opportunity of studying at first hand group practices throughout the country. There are many types of groups, each serving the purpose for which it was organized.

Particularly in the western part of the country, numerous small groups have been established as partnerships by from five to 20 doctors who envisioned the benefits that would accrue from a cooperative enterprise. They appreciated the value of having within one organization the services of specialists in various fields. They likewise acknowledged the financial stability and economy that such an enterprise would effect. The facilities they could provide collectively were beyond the reach of any one of them. Furthermore, their arrangements often would permit time for postgraduate study and training.

Since these groups are actually partnerships, the participants distribute the "profits" equally or by any prearranged method. Although incomes are modest in many of these groups, there seems to be a feeling of satisfaction that is frequently not found in the individual practitioner.

A few of the larger groups employ doctors on a salary basis before admitting them to partnership. In some smaller groups, particularly those associated with a university or endowed through a foundation, a salary basis without incentive bonus is utilized. The patients in these groups usually pay either a modest fixed fee or according to their ability to pay for service received.

One is impressed with the sincere effort to "do good medicine" demonstrated by the individual members of the group. While the quality of the service depends on the character and training of the individual practitioners, there can be little doubt that the practice is usually superior to that which could be offered by any one of the individual physicians of the group.

Some of these groups have grown to large organizations of hundreds of doctors. Sound business principles have been developed with the result that they remain successful and are perpetuated beyond the life span of the founders. In organizations of such proportion, the usual method of compensating for physician service is on a salary basis. Some groups have added retirement and security benefits which appeal particularly to the young physician.

Because they offer services of high quality to their patients, they have become popular and nationwide in their influence. Perhaps they have lost their community atmosphere, but there can be little doubt as to the value of the medical service they are rendering.

Many of the larger groups have instituted provision for postgraduate training, either within the group or in conjunction with the associated hospitals. Most of them render service on a fee-for-service basis and adjust the fees according to the financial ability of their patients. However, since their services are not limited to their community, the number of charity cases is limited. The services are usually limited to diagnostic and curative measures.

A few groups, notably on the West Coast and in industry, have established prepaid comprehensive services. They include preventive medicine as well as diagnostic and curative services. Such groups now serve only individuals who pay the premiums themselves or with the help of their employers. At the moment the indigent are not included. These groups distribute the cost of medical care among all of the subscribers and not among the sick patients only. They employ the insurance principle and thus lower the cost to a level that enables more people to obtain protection.

The quality of medical service rendered by such groups is again de-

pendent on the type and qualifications of the doctors within the group, as is true with individual practicing physicians. This fact is frequently overlooked in discussing group practices. The doctors within these groups are paid on a salary basis comparable to that of the community and proportionate to their individual ability. Many believe that complete comprehensive care cannot be rendered except through groups.

Most notable among group practices, however, are the groups in voluntary and municipal hospitals that render medical care to the indigent patients in the wards and out-patient departments of the hospitals. The group organization in most of these hospitals does not require the full time of the physicians. Most of them are practicing physicians who devote a certain portion of their time to "charity work." These men, as a rule, receive little if any remuneration for their work. As a result, the best physicians in the community constitute the staff of such groups.

Best Care Not Always Assured

Observation over a long period of time leads one to the conclusion that the excellence of medical care being offered in these groups is not always assured. This is probably due to the fact that these physicians render only part-time service and do not have the total responsibility of the work performed in the groups. The hospitals, on the other hand, receive from these patients only a fraction of the cost of rendering such services. Such group practices, therefore, are restricted to the poor or indigent.

Such groups have also accepted the responsibility of instituting most successful programs for postgraduate training, which assure the perpetuation of well-trained physicians. These trainees, the intern and resident staffs of the hospital, render medical care under the supervision of the attending staff.

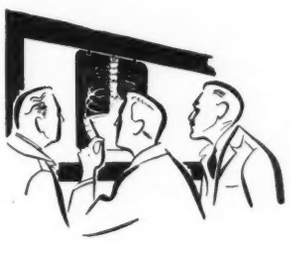
We should not overlook this valuable training that hospitals with ward and out-patient services provide. Naturally, those hospitals associated with medical schools have the added responsibility of undergraduate teaching. Adequate intern and resident training does not seem possible without participation in the total care of the patient. Both ambulatory and hospital care are necessary for adequate training. To complete the training, domiciliary care should also be added.

The question naturally arises whether it is necessary to have indigent patients in order to carry out this important teaching function. In at least three institutions which I visited, adequate postgraduate teaching and training were being carried out and, in one, excellent undergraduate teaching was included without distinction as to the financial status of the patients. These individuals were patients of the group even though they occupied private rooms or paid more than average fees. The type of case rather than the type of individual seems to be the important factor.

Under such a system each patient is assured competent consultation service, and the physician's time is reserved for those functions for which he is best trained. In the private practice of medicine well-trained physicians spend considerable time performing functions that could be carried out by younger doctors.

Irrespective of the type of organization, the application of the group principle contributes to the efficient and economical distribution of medical care. Under such a system it is easier to provide adequate facilities and the services of specialists.

During the past few years fewer patients have been admitted to the wards and out-patient departments of



hospitals. In part this has been due to the period of relative prosperity which has enabled more patients to pay for their medical care. The success of the Blue Cross hospitalization plan has also contributed to the numbers obtaining semiprivate accommodations.

More recently the extension of insurance plans for medical care, particularly those sponsored by the medical societies, has had its effect on the trend toward private and semiprivate accommodations. Possible compulsory health insurance plans, either on a state or on a federal level, will have similar effects. All this seems to indicate an ultimate abolition of the medically indigent group.

Such a consequence might likewise indicate the possible abolition of the important function of teaching and training now being performed in hospitals with out-patient and ward services. That function should be perpetuated, and the governing boards of hospitals, as well as their medical staffs, must accept the challenge.

Certainly the abolition of the indigent group should not be deplored. The group practices now operating in the wards and out-patient departments of voluntary hospitals should be continued. This might be accomplished by converting such groups into self-supporting enterprises that would permit the admission of patients for whom the cost of service rendered is paid either by insurance or by the patients themselves. In such an undertaking, the services of the medical profession would be paid for either by the hospital or by the operation of the unit by the doctors themselves.

Convert Out-Patient Clinics

Structural alterations would be necessary to convert present out-patient facilities into units comparable to private group practices. Alteration of ward services would likewise be necessary. The group practices now in operation could thus be continued and a satisfactory teaching and training program could be assured.

These are important considerations which present themselves to the trustees of hospitals. At the present time most hospitals are contemplating additions to their private and semiprivate services. Are these actually needed, or does the demand for those services indicate a decrease in ward services? If the latter is true, what we need is conversion rather than addition.

The success of group practices everywhere and the increasing interest in group practice on the part of the medical profession, together with the development of prepaid comprehensive medical care programs, would indicate that more liberalized group practices within existing hospitals offer a fertile field for future development.

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Science Service
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Now They Can Be Told

WAR SECRETS

that saved lives

WHEN the atomic bomb burst over Hiroshima it shattered a major military secret of the war along with the buildings of the Jap army base. Since then more and more war secrets are being told. Strange code names and numbers—NMRI 407, ANTU, 1080, TGHI—are becoming familiar words as a slightly bewildered public learns how war has brought to peace new ways of saving and prolonging life, of making it more comfortable and of eliminating pests that are both a danger and a nuisance.

Among the earliest nonmilitary practical applications officially foreseen for nuclear energy which powered the atomic bomb are medical uses. Details have not yet been disclosed, perhaps not yet worked out. But long before industry is powered by nuclear energy, x-rays and radium for treating disease will be augmented by new and increased sources of radioactivity developed in the work that led to the atomic bomb.

Many Chemical Developments

Chemical warfare, with its connotation of poison gas attacks, has long terrified civilian imaginations in spite of the fact that experts in this field know it to be the most humane kind of warfare, if any warfare can be called humane. Many will be surprised to learn that from this branch of our military service are coming many useful developments for peace, among them some of special value in man's fight against disease and death.

First of such chemical warfare secrets that has been told since the war's end is the story of 1080. This is a chemical rat killer which appears to be just as deadly to rodent pests as DDT is to flies and mosquitoes. To anyone knowing the diseases spread by rats, from bubonic plague to food poisoning, the health protection value of a super rat killer needs no emphasis.

Now that the war secrets are being told, it turns out that we have two such chemicals for our peace-time war on rats. One is 1080. The other is ANTU.

1080, a joint baby of the Chemical Warfare Service of the Army, Office of Scientific Research and Development and the U. S. Fish and Wildlife Service, is sodium fluoroacetate. This new ratbane seems to be the deadliest stuff ever tried out for the purpose. In carefully controlled tests, it has been able to kill the common Norway rat in concentrations as low as 5 milligrams per kilogram of body weight. That means that if a rat weighing ½ pound swallows a pinpoint speck of it weighing less than 0.0002 ounce, he will die. To certain other rodents, such as prairie dogs, 1080 is deadly in even smaller doses.

One advantage of 1080 is its easy solubility in water. This makes it possible to dilute it down to manageable doses and probably also to add disguising scents or tastes in case rats become too wary. However, the latter precaution should not be necessary; if a rat-infested area is properly baited with 1080 there will be no survivors to teach a younger generation caution. The high solubility of 1080 also makes it possible to offer it to rats in simple water baits; ⅓ ounce in a gallon of water has proved quite effective in field tests.

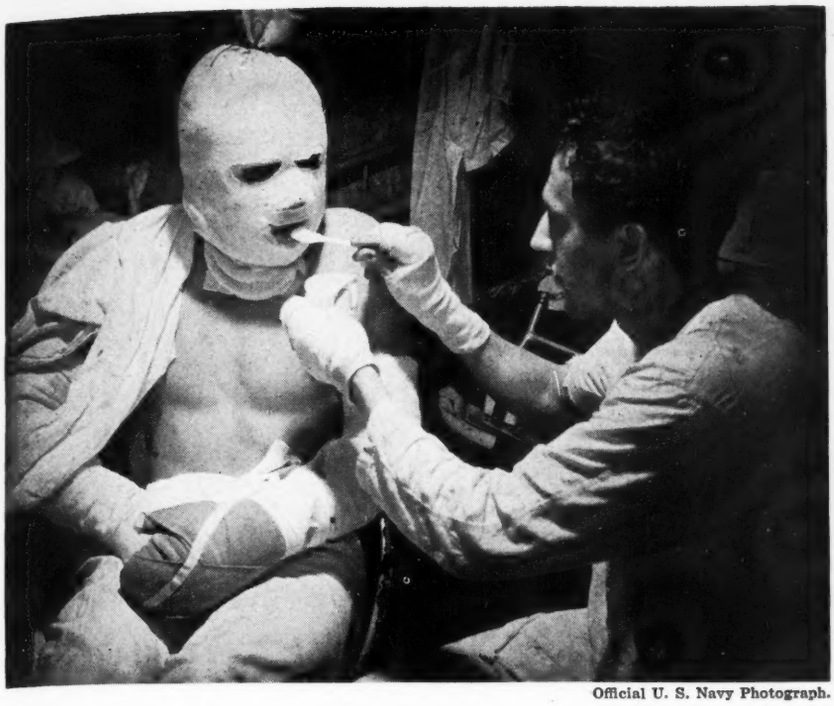
The deadliness of 1080, however, should not be played down, all workers with the stuff agree. One rat died in exactly 20 minutes after drinking water containing it, and at the end of two hours about a score of dead rats were picked up in the vicinity. It is no respecter of animals and will kill pet dogs and cats and probably game and livestock, if they inadvertently get hold of it. For this reason, it is unlikely to be put on the market for general household use but is more likely to be put in the hands of professional rodent-killers who wage campaigns against rats among wharves, granaries and warehouses and against too numerous prairie dogs and ground squirrels on western rangelands.

The high dilution in which 1080 can be used is one thing that will make it less dangerous, Dr. Ray Treichler of the Fish and Wildlife Service points out. It would be necessary for a man to eat 6 ounces of an ordinary bait containing it to get a lethal dose. If a little is swallowed it is soon excreted; its effects are not cumulative like those of many other poisons. Moreover, it is not absorbed through the skin like one of the rodenticides now in general professional use; this is a great practical advantage in field handling.

ANTU for Domestic Use

ANTU seems more likely to be destined for use as a domestic rat killer and in anti-rat campaigns in residential sections of cities, because it apparently has a greater safety factor. In fact, one of the peculiar things about ANTU is that it acts almost exclusively against the Norway rat. Cats and dogs can be poisoned by it, but in widespread field trials in Baltimore accidental poisoning of either pet or stray domestic animals did not become a serious problem. Furthermore, no cases of human ANTU poisoning occurred, although 500,000 persons were exposed to it as they would be to any other rat poison used in an almost citywide campaign.

Chemically, this rat killer is alpha-naphthyl thiourea. Compared to other rat poisons, it is twice as poisonous as thallium sulfate and more than 100 times as poisonous as arsenic trioxide and fortified red squill, on



Official U. S. Navy Photograph.

Medical discoveries that have come out of the war have saved the lives of an enormous number of men, such as this victim of a Japanese kamikaze assault.

the basis of the sizes of the killing doses of each.

ANTU was discovered by Dr. Curt P. Richter of Johns Hopkins Hospital in the course of taste tests in rats made as part of his studies of taste as a guide to food selection.

One afternoon he gave the rats a chemical often used for taste tests in human beings. This is phenyl thiourea, which tastes extremely bitter to most persons though some cannot taste it at all. As is done in the tests on human beings, a few crystals of the chemical were put on the tongues of rats.

All the rats in the test were dead the next morning. This was a surprise, because phenyl thiourea previously had been considered nonpoisonous. It had been safely used for a long time for taste and inheritance studies in large numbers of people.

The war value of this discovery was immediately apparent. Red squill, which is imported, was no longer available and other rat poisons were either in short supply or dangerous. At the same time, the danger of epidemics of typhus fever and other rat-borne plagues might increase during the war. So, at the suggestion of Col. Perrin Long, Doctor Richter continued to study phenyl thiourea under a grant from the Office of Scientific Research and Development.

He soon found that although the rats in his laboratory would eat enough of the chemical in their food to poison themselves, wild rats in the city dumps and grocery stores of Baltimore were more wary. Apparently the bitter taste of the chemical warned the rats or at least kept them from eating bait poisoned with it.

A search for related chemicals was made with the help of the E. I. duPont de Nemours Company which quickly supplied more than 100 samples. Of these, alpha-naphthyl thiourea turned out to be the best. It is made from alpha-naphthyl amine and ammonium thiocyanate. These chemicals, commonly used in the dye industry, are not expensive and were not on the list of critical chemicals during the war.

Surprising and somewhat disappointing was the discovery that while ANTU is highly poisonous to the Norway rat, the Alexandrine or black rat commonly found in many parts of the world is not as much affected by the poison.

Besides its almost exclusive action on rats, ANTU has another remarkable feature: It kills the rats by causing a drowning pulmonary edema. It is the only substance known to produce an edema limited to the lungs.

Ranking close to rats in their power to cause disease and death among human beings are insects. The secret of DDT was told during the war when its use as a delousing powder stopped the typhus epidemic in Naples. New facts about it keep coming to light as scientists progress in their studies.

The dramatic aspects of its power to kill lice that spread typhus, mosquitoes that spread malaria, yellow fever and dengue and flies that spread other diseases, as well as destroying human comfort, have somewhat overshadowed more prosaic facts, such as its triumph over the bedbug and the fact that different preparations of it are needed for specific uses. The name DDT, as many have read but forgotten, is made of the initial letters of the chemical, dichloro-diphenyl trichlorethane. Entomologists who have observed the behavior of flies and other insects just before they die of DDT poisoning, however, say the letters stand for "double delirium tremens."

Even with a super insect killer like DDT available, there are situations in which life and health as well as comfort depend on being able to hold insects at bay. To protect men fighting in the jungles, our Army and Navy have developed a number of potent insect repellents.

The secret of the newest and apparently best of these, NMRI 407, has just been told. The letters stand for Naval Medical Research Institute, at which 407 and 448 in a series of many hundreds of chemicals were developed.

In the laboratory, a man can smear a few drops of either of these liquids over his hand and arm and keep it in a hot, humid cage full of mosquitoes for hours without being bitten. The sweat that stands out on his skin because of the tropical atmosphere in the cage, or drips off when he exercises, fails to reduce the effectiveness of 407. It repels mosquitoes for over five hours. Mosquitoes bite a little sooner, in 289 minutes instead of 322 on the average, when 448 is used, but the latter is much less expensive so may turn out to be more practical.

Field trials are expected to show what these chemicals will mean for comfort and health protection of

workers in jungles and other mosquito-infected regions. An earlier repellent, NMRI 201, held the insects at bay more than twice as long under field conditions as in its laboratory trials. The exact chemical identity of these repellents has not yet been revealed but the Navy report states that they are hydrogenated naphthols. Mixing these naphthols with another chemical, 2 phenyl cyclohexanol, prolonged their repelling time.

Campers and explorers will be interested in TGHI, a war-developed water disinfectant for emergency field use. Chlorine and chlorine compounds, stand-bys in water disinfection for almost forty years, as ordinarily used cannot be counted on to protect troops in the field from amebic dysentery or schistosomiasis. The parasites of these diseases when in the cyst stage are too resistant to disinfection by such means. It would take at least six standard p-sulfonedichloramidobenzoic acid (halazone) tablets, for example, to ensure disinfection of a canteen full of warm water in thirty-six minutes. After this treatment, the soldier probably would not drink the water because the taste would be so unpleasant.

Search, under OSRD contracts, for more satisfactory canteen disinfectants was focused on quarternary ammonium compounds and tri-iodides and finally led to TGHI, or triglycine hydrotriodide. This, Prof. Gordon M. Fair of Harvard reports, possesses the most desirable properties of any tri-iodides so far developed and tested.

Taste Is Not Objectionable

The disinfectant has been prepared in the form of stable, quickly dissolving tablets which liberate enough elemental iodine to kill cysts of E. histolytica in a few minutes and to reduce the number of typhoid, paratyphoid B, cholera and bacillary dysentery organisms from about a hundred million to 5 or less per 100 cc. of water. These disinfecting results can also be obtained with tincture of iodine, but the tri-iodide tablets give a better tasting water besides being easier to handle than a liquid disinfectant. Soldiers and marines who have tried the tablets did not find the taste or odor of TGHI-disinfected water objectionable.

"Possibly toxic effects are expected to be sufficiently rare in a military population to permit the use of tri-iodide disinfection under emergency field conditions," Professor Fair states.

Some of the most significant medical developments of the war, such as the blood fractions and the antibiotics, have not been kept secret. Everyone has heard the dramatic stories of blood plasma and albumin and penicillin. Less well known but no secret to medical men have been the aid to surgery furnished by fibrin film and fibrin foam; the protective action against measles and, apparently, infectious hepatitis furnished by gamma globulin; improvement in blood typing offered by the isohemagglutinins, and the value of streptomycin in conjunction with penicillin for stubborn infections and by itself, according to present indications, in tularemia and tuberculosis.

Penicillin shows some promise of becoming a useful food preservative, although work along this line has not progressed far enough yet to give more than a hint of such a development.

Auxiliary to penicillin and the sulfa drugs is an antiseptic developed by British scientists and short-named phenoxetol. One of its chemical names is ethyleneglycolmonophenylether. Less effective against streptococci and staphylococci than penicillin or the sulfa drugs, phenoxetol is more effective against the pyocyaneus bacillus. Surgeons of World War I will remember the "blue pus" in wounds infected with these organisms and the delayed healing which often followed. The new antiseptic gave good results in treatment of surface wounds associated with skin loss, such as burns, scientists at the Welsh National School of Medicine found.

From overseas also has recently come news of another chemical, of possible use as an antiseptic, whose antibacterial properties were explored at the Institute of Public Health in Stockholm. This is the rather poetically named pinosylvine, produced by the pine tree and serving to protect the tree's dead heart-wood against wood-decaying fungus and insects.

Chemically, pinosylvine is a derivative of stilbene and closely related to resorcine and hexylresorcine. It seems to have the strongest germicidal power of any phenol substance found in nature and isolated, but it also has greater toxic action than phenol though the toxic symptoms are different. Whether these can be reduced to the point where the substance would be a safe antiseptic has not yet been reported.

No secret to medical officers of the Army and Navy, though perhaps not yet too well known to their civilian colleagues, is the benefit gained by surgical and medical patients through systematic and prescribed physical exercise which, in service hospitals, starts while the patients are still in bed and, in some cases quite literally, just able to wiggle their fingers and toes. It is the program which made many a sick or wounded G.I. wonder whether he had been taken to a hospital or a gymnasium, but it helped him get well faster and protected him from boredom and loss of muscle strength.

Quite unexpected results were obtained in transverse myelitis cases in which the spinal injury caused paralysis from the waist down. Arm and trunk muscles were strengthened by the exercises to the point where the patients could get around without help; formation of bladder or kidney stones and decalcification of the bones of the legs and feet, formerly troublesome complications in these cases, were prevented.

Glass for Wound Dressings

The idea of using glass in dressings for wounds may startle many persons and bring back memories of one of the atrocity stories current during World War I, that German agents put ground glass into surgical dressings used on our wounded men. Yet one Army surgeon, Capt. Ronald M. Buck, reported at a recent surgical conference of the Sixth Service Command that glass cloth makes a better dressing for wounds than vaseline impregnated gauze. He also found it satisfactory as the first layer of a wet dressing for a split skin graft.

Glass, it appears, is going into surgery in still another way. While not exactly a war development or secret, a report of its use as a bandage in fractures has just been made by Dr. Roger Anderson and Herbert R. Erickson of Seattle. From this one may assume that patients with broken bones in future may find themselves wearing lightweight, flexible bandages of glass and plastic instead of heavy, cumbersome plaster-of-paris casts.

A Plan for Improving

HOSPITAL TREATMENT of PSYCHIATRIC PATIENTS

Lt. (j.g.) LESTER LEE HASENBUSH and GRACE G. HASENBUSH

This essay won the first prize of $500 in the contest sponsored by The* MODERN HOSPITAL *on improving the care of psychiatric patients

AS THE world turns from years of war to peace, medical science faces no greater challenge than that presented by the needs of the mentally ill. Three reasons for the urgency of this challenge are:

1. The number of people hospitalized in mental disease institutions is so vast that in the United States more than half of the hospital beds are occupied by these patients. Problems in this field were high-lighted during the recent war when a large percentage of the men and women was turned away from draft boards and induction centers or invalided from the service because of psychiatric disabilities.

2. The generally available personnel and facilities for psychiatric hospitals too often fail to give the patient the benefit of modern psychiatric treatment.

3. Inadequate measures to prevent and treat mental illness result in untold personal suffering and tremendous loss to society in terms of wasted human productivity.

There is a wide divergence in the quality of treatment in mental disease hospitals. Relatively few institutions, either public or private, have superior standards of psychiatric and general medical therapy. In general (with the possible exception of some of the small unlicensed private institutions operated for profit) the greatest need for improved psychiatric treatment lies in the public hospital group which cares for 97 per cent of all patients in mental disease hospitals. We shall have these particularly in mind in describing some of the objectionable conditions and practices in psychiatric hospitals without necessarily inferring that such conditions are universal.

Objectionable conditions and practices in psychiatric hospitals

The constantly increasing numbers of psychiatric hospital patients have resulted in institutions that are too large for efficient administration and for adequate provision for the needs of individual patients. Despite their size, in many such hospitals patients of discordant types must be housed together in wards filled beyond their planned capacities. Hospitals are often located in relatively inaccessible areas. Their buildings are often cheerless, prison-like and lacking in necessary facilities for the treatment and comfort of the patients.

Usually the patient-physician ratio is so large and the time of the doctors so occupied with administrative matters, that well-planned treatment programs, including psychotherapy, are quite neglected. The level of specialized psychiatric training among the doctors, nurses (another seriously understaffed group) and attendants is usually low and their pay is unattractive.

One finds too much dependence on trial and error methods of gaining experience, punitive attitudes on the part of assistants and the too free usage of seclusion and mechanical and pharmacological restraints. The physicians in many hospitals are isolated from the remainder of the medical profession. Well-trained auxiliary personnel, such as social workers, psychologists, therapists and secretaries, is usually represented too sparsely if at all.

In some hospitals two serious obstacles to the coordination of the efforts of the physicians, nurses and other personnel are: (1) the impeding division of authority between

medical and lay officials and (2) the rôle of political influence in hospital appointments and promotions.

We must also remember that in some states prior to his admission to the hospital the patient's illness may have been aggravated by the trauma of court commitment and by having been brought to the hospital by law enforcement officers.

General plan for improving hospital treatment of psychiatric patients

Good facilities for the prevention, early diagnosis and treatment of psychiatric illness should be available to people in local districts, whenever possible within convenient distances from their homes. We suggest that an average district serve a population of approximately 250,000 people.[1] Its area would depend upon population density as well as varying socio-economic factors.

Public hospital facilities in the district should include a state-owned mental health center and a state psychiatric hospital. These should be supervised and coordinated by a state department or board free of political manipulation and having matters pertaining to the hospital treatment of psychiatric patients as its sole function. Such a plan would increase the number of psychiatric hospitals and stimulate a spirit of healthy competition among them. In states too poor to provide adequately for the hospital treatment of psychiatric patients, federal aid should be sought.

Mental health center

The mental health center should be readily accessible to the hub of population in each district and in proximity to a general hospital where medical and surgical consultation, x-ray and clinical and pathological laboratory service would be available. We shall attempt to outline briefly its organization which, in some respects, we propose to model after a good so-called psychopathic hospital. We prefer to call it a mental health center to focus attention on mental health in contrast to mental disease and to emphasize the preventive, therapeutic, educational and investigative aspects of psychiatry.

The center should be prepared to receive public patients referred for early diagnosis and treatment by local physicians and hospitals, social agencies, courts, industry, schools and district residents.

It should be directed by a qualified psychiatrist aided by a sufficient number of full-time physicians, including interns, and also by a part-time staff. There should be departments of medicine, nursing and social service.

The medical department should have a ward service and an out-patient service. The ward service should have provisions for the prompt admission and short-term study and treatment of local psychiatric patients and should have a capacity of about 100 beds. Patients should be retained for treatment if they are considered capable of being discharged within sixty days to their homes or to a family care plan with follow-up treatment in the out-patient service. Patients requiring prolonged care are to be sent to the state psychiatric hospital.

The out-patient service should have separate facilities for adults and children. In addition to individual and group psychotherapy, this service should provide a flexible system of ambulatory treatment whereby patients may come for psychiatrically guided activity programs utilizing the various facilities of the center. Besides the sources of patients noted above, it should receive patients for after-care following their discharge from the center's ward service or from the state hospital.

In addition to treating the patients themselves, special emphasis should be placed on a psychotherapy program for the families of psychiatric patients. Individual interviews with such families should be supplemented by lectures, group discussions and appropriate literature. Similar efforts should be made in treating the parents of children requiring guidance.

Under the director of the department of medicine provision should be made to contribute to the psychiatric training of staff physicians, interns and other interested doctors, both those in the state employ and those in private practice.

An educational program under the director of the nursing department should also be made available for nurses and psychiatric technicians.[2] We recommend that as far as possible these medical and nursing educational programs be organized along lines to be discussed in connection with the state hospital.

State psychiatric hospital

The state psychiatric hospital should, if possible, be located on a large tract of land in a suburban area and be provided with good public transportation to bring it into as close touch as possible with population centers. It should have a capacity of approximately 1500 beds. The construction of such hospitals would enable existing outsized older ones gradually to decrease their capacities.

The state hospital should receive patients who for the most part need prolonged treatment. They would be chiefly residents of the district and would be referred from the mental health center and local doctors. In addition, psychotic and defective delinquents would be referred from courts.

We believe it advantageous to organize the hospital into departments under a well-qualified superintendent. He should serve as chairman of a hospital council composed of the directors of the various hospital departments. Considerable responsibility should be placed in the hands of these directors. There should be the following departments: (1) administrative, (2) medical, (3) nursing, (4) social service, (5) rehabilitation.

Administrative Department. This should include such subdepartments as maintenance, purchasing and clinical records. Necessary office and maintenance employes should be under the supervision of this department. Work performed by patients on the grounds or in the laundry should be under the supervision of the subdepartment of maintenance. Such work should not interfere with time necessary for the patient's participation in recommended psychotherapy and rehabilitation programs. The administrative department

[1] We are assuming that the actual need of the average community for psychiatric hospitalization is approximately 635 beds per hundred thousand persons in the population, a figure well above what is now generally available.

[2] The term "attendant" too often carries a stigma and we suggest instead the use of the U. S. Navy term "psychiatric technician" which flags attention to the fact that the worker is trained.

should be responsible for seeing (insofar as the individual patient's condition permits) that the patients are not lacking personal needs like respectable clothing.

Medical Department. The department should include a well-qualified psychiatrist as director and staff physicians, consultants and interns. There should be subdepartments of psychology and physical therapy. The functions of the doctors should include psychotherapy, both individual and group, and general medical care. In addition, the doctors should be prepared to use, when indicated, various special therapeutic procedures, such as the induction of coma, convulsions, narcosynthesis, prolonged narcosis and hyperpyrexia. They should keep adequate clinical records.

Qualifications for appointment to the department should include a good general medical background. The extent of required previous psychiatric training should vary with the responsibilities of the position, but all of the physicians should be interested in dynamic psychiatry.[3]

In order to promote the concept of active therapy as the primary purpose of the hospital in contrast to custodial care, the medical department should be divided into services for patients grouped chiefly according to their therapeutic needs and ability to adjust rather than on the basis of diagnosis. These services should provide separate facilities for males and females, and should be organized somewhat as follows:

An *admission service* to provide for the introduction of new patients into the hospital environment and for their prompt initial examination and classification for distribution to other services. This should be divided into two sections, one for the more disturbed patients and one for quiet patients.

A distinct *service for disturbed patients* divided into two sections. One of these should be for patients with a predominance of psychomotor overactivity and agitation where special attention can be readily devoted to therapy designed to aid in channeling and redirecting energy and in releasing tension. The other section should provide for patients with leading trends of psychomotor retardation and depression where the attention of personnel can be given to mobilizing latent energies.

A *closed ward service for quiet patients* requiring close supervision; an *open ward service* for patients with "grounds responsibilities."[4]

A *convalescent service* to give convalescing patients a program in which gradually more time is spent away from the hospital. For a period before their discharge, patients would be granted increased responsibilities for participation and readjustment in community life, including home visits and perhaps occupational experience.

We consider commendable the trend to provide care outside of psychiatric hospitals for the nonpsychotic and nondelinquent mentally defective and epileptic patients and do not suggest special services for them in the medical service. However, we do suggest additional separate services for special groups in order to give them the most effective attention and to facilitate research.

We would provide services for the study and treatment of psychotic children, alcoholic patients, the senile, and the psychotic and defective delinquents.

A *custodial service* with open and closed ward facilities should be reserved for patients who fail to respond to prolonged intensive treatment or who have such extensive and fixed disabilities that they are considered unable to benefit from such therapy.

There should also be an *infirmary service* organized along the lines of a general hospital with good facilities, including modern x-ray apparatus, clinical laboratories and operating rooms for the practice of surgery and medicine, their various specialties and dentistry.

A *research service* would house selected groups of patients for the study of special diagnostic and therapeutic problems and would be prepared to cooperate with the research activities of other services when requested.

Opportunities for the psychiatric education of resident and staff doctors and other interested physicians should be provided under the supervision of the director of the department of medicine. These might include supervised experience with patients, lectures, case presentations and a useful library. If there is a medical school in the district, there should be a close affiliation to aid in the psychiatric teaching of the students and to provide the hospital with lecturers and consultants from the medical school faculty.

Nursing Department. The director of this department should supervise the nurses and psychiatric technicians. The employment of graduate nurses is highly desirable. Members of this department should aid in transporting patients to the hospital when the families are unable to do so alone. We approve the trend to discontinue state hospital schools of nursing because they can seldom provide the rounded experience necessary to train very good nurses, such as can be offered by schools in general hospitals.

However, we strongly urge state hospital affiliation with such schools of nursing where possible, so that student nurses can be provided with psychiatric training and so that the hospital nurses can have the stimulation of an educational environment. In addition, courses should be given to staff nurses in psychiatric orientation.

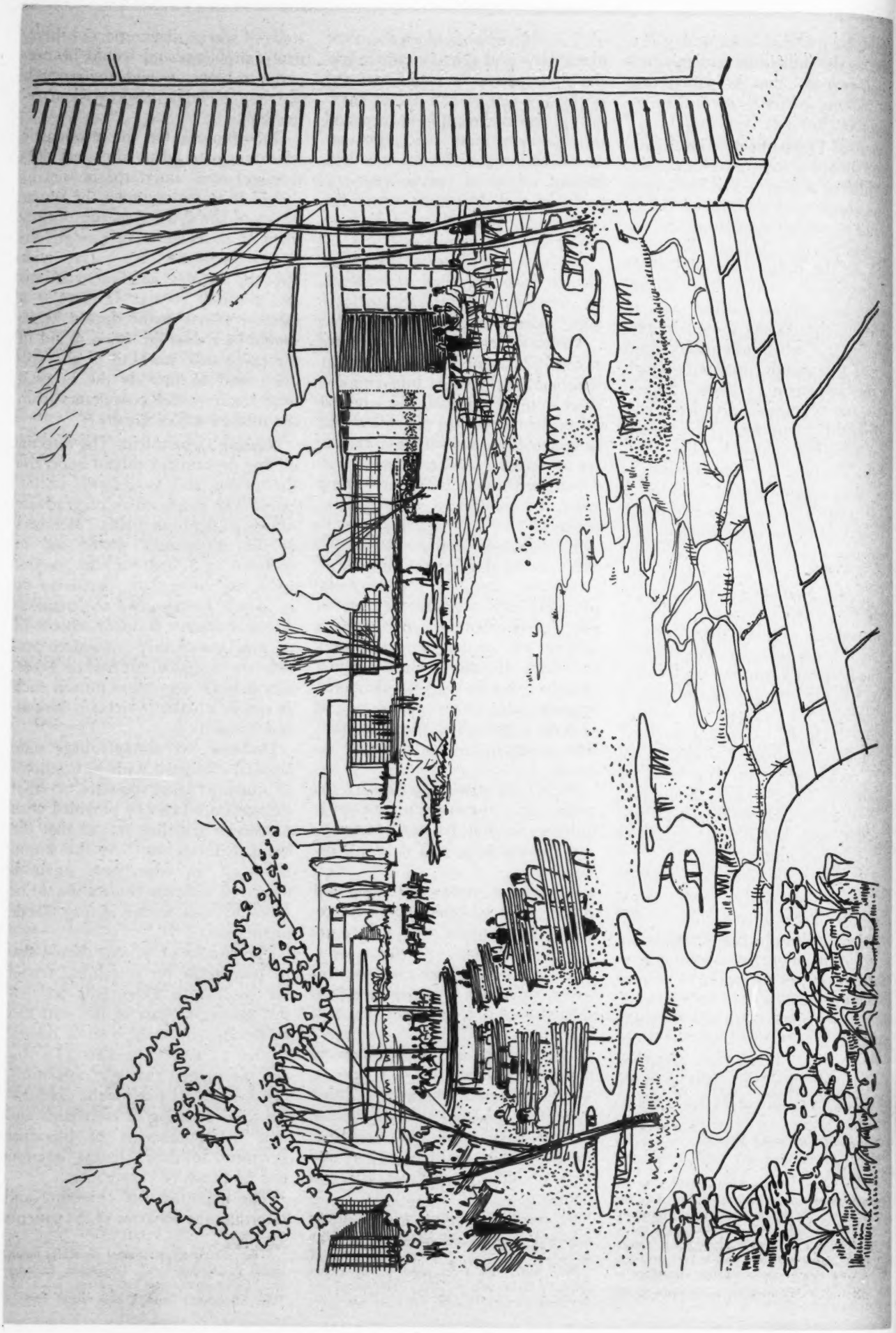
The director of nursing should also be responsible for a training school for psychiatric technicians so that this important part of the staff can be elevated from the level of menial to that of skilled workers. To this end we suggest that a greater number of states provide for the examination and licensing of attendants and that the publication of literature pertinent to their clinical interests and problems be encouraged.[5]

The importance of observing and recording the behavior of the patients

[3]To encourage more physicians to become qualified psychiatrists, psychiatry should not be officially quite so closely linked to neurology, which is of only limited interest to the doctor engaged in the hospital treatment of the mentally ill. Psychiatry would gain, however, if it were officially more closely linked to internal medicine of which neurology is a part. Therefore, the national board for certifying diplomates should not emphasize neurology to an extent that relegates the remainder of internal medicine to the background.

[4]We prefer this term, used in the Henry Phipps Psychiatric Clinic, Baltimore, to "grounds parole."

[5]The Attendant (a national monthly, magazine), P. O. Box 6000, Torresdale, Philadelphia, Commonwealth Fund; Stern, Edith M.: "The Attendant's Guide," New York, 1945.



and their interpersonal relationships should be emphasized in the training programs outlined. The nursing staff should not be shifted from ward to ward so often as to prevent the development of therapeutically effective relationships with patients.

Social Service Department. The director of the department should be an experienced graduate social worker. Other staff members should have at least some graduate training. The social worker has been called the reciprocal part or counterpart of the psychiatrist, working with the general environment to fit the needs of the patient, while the doctor attempts to help patient fit environment.

The social worker's functions include obtaining family histories, aiding in interpreting the patient's illness and needs to his family and in modifying family attitudes in directions conducive to the patient's recovery. Where family care plans are available, she has a large responsibility in placement, in overseeing the kind of care the patient obtains in his foster home and, for these patients and discharged patients, she must see that there is the necessary follow-up treatment in the outpatient department of the district mental health center.

Rehabilitation Department. The aims of this department should be the promotion of personal satisfaction and self-confidence by the release of emotions through acceptable outlets, *i.e.* the performance of work, learning new technics and interests and socialization. In addition, the department should serve to promote the general physical fitness of patients. It should consist of a director in charge of three units, each under a supervisor: (1) ***a community activity unit,*** (2) ***a hobby unit*** and (3) ***an educational unit*** for academic and vocational training.

The rehabilitation director should be specially trained in this field and qualified to plan a training program for junior assistants. Under the director there should be full-time experts in charge of the three units and these individuals should be assisted by an adequate number of full-time workers and by part-time aides, such as music teachers and volunteers from the hospital personnel, the patient group and the community at large.

Plans and programs for the department should be organized by the rehabilitation director in cooperation with a rehabilitation board composed of the members of the hospital council, the three supervisors of the units of the rehabilitation department and the supervising psychologist.

The participation of patients in the rehabilitation program should be considered a part of therapy and not entirely volitional. However, no effort should be spared to gain a patient's willing participation and interest.

The physician should provide the rehabilitation director with a brief summary of the patient's condition and needs, with succinct suggestions as to his rehabilitation program, and the psychologist and the social worker should provide further data as to the patient's aptitudes and interests.

The three units of the department might be planned as follows:

Community Activity Unit. This should be housed in a building with facilities for the following activities: (a) Physical training. A daily program of physical activity should be provided for patients according to medical recommendation. In addition to exercises and games in the gymnasium, appropriate physical activities should be planned for bed patients and disturbed patients who cannot visit the gymnasium. (b) Group entertainment, such as movies, dances, music, amateur theatricals and visiting entertainers, should be housed in an assembly hall. (c) Chapel services should be available.

Hobby Unit. The emphasis in this unit should be placed on therapeutic benefits to the patient and not on the perfection of his productions. A diversified group of facilities and activities should be available so that patients of varied needs and interests can participate in the program in the hobby building or on the wards.

Facilities could include a patients' library with both general reading and literature useful as bibliotherapy; a handicrafts section; a music section for individual and group lessons in voice and instrumental music, orchestras and music appreciation; an art section for painting and finger painting, sculpture and poster work; sections for learning household arts; a carpentry shop; special hobby clubs for nature study and photography; a mimeographed publication written by and for patients under staff supervision. There should be frequent displays both of articles made by patients and of interesting exhibits lent by community sources such as museums.

Academic and Vocational Educational Unit. Attempts should be made to utilize near-by community vocational and academic facilities for convalescent patients. However, because these are seldom available to many patients, a suitable program should be established in the unit. The cooperation of municipal and county departments of education should be sought in organizing a program and in obtaining teachers.

For academic training, grade and high school classes might be organized, depending upon needs of the patient group. For vocational training we recommend that after consultation with the United States Employment Service, a practical program of vocational rehabilitation be organized, based upon the opportunities for work in the community and the abilities and interests of the patients. The social service department, cooperating with the U.S.E.S. (division for the handicapped), should aid in the vocational placement of the patients.

This sketch by Edgar Firant of Chicago envisions the central plaza of the "village plan" of organization for a state psychiatric hospital which is described on page 70. The administrative buildings form a hollow square around the attractively landscaped plaza with a bandstand for outdoor music and benches scattered among the trees and shrubbery. Behind these buildings the authors propose to place living quarters for the staff members and about 15 separate one story cottages that would house 100 patients in each.

Personnel in psychiatric hospitals

The well-being of the patient and the satisfactory functioning of every aspect of a hospital depend upon adequate numbers of well-trained and efficient

personnel. To this end we suggest that in state hospitals all personnel be employed under a civil service system free of politics, requiring higher standards of professional and technical training and of personal qualifications.

As has already been indicated, various groups of personnel should be provided with special training programs in the mental health center and the state hospital and, in addition, all personnel should be encouraged to utilize other educational facilities in the district.

To encourage a greater number of people to work in psychiatric hospitals and to attract individuals who meet the requirements outlined, it is necessary to pay higher salaries and to improve working conditions. Salary scales should compare favorably with those in private pursuits and federal employment. Improved working conditions should include such features as reasonably limited hours of work, vacations with pay, provisions for health insurance and retirement pensions and good housing and recreational facilities.

Physical environment of psychiatric hospitals

Too often the therapeutic rôle of the physical aspects of the hospital environment is not thoroughly appreciated. The ideal environment should contribute to the patient's comfort, promote his feeling of security and acceptance and appeal to his esthetic sense.

Hospital structures for psychiatric patients should be built according to the best principles of modern architecture. They should be spacious without being overlarge and with adequate space thoughtfully planned for their many facilities. For example, private examining rooms readily accessible to both patient and doctor constitute a need often overlooked.

These buildings should have large windows with inconspicuous safety-detention features that do not interfere with light or ventilation.

Wherever the patient spends his time, whether it is a waiting room in an out-patient service, a ward for geriatric patients or a dining hall, every attempt should be made to create a cheerful and personalized, yet simple and safe, setting with special attention to such features as the decorative use of color, sturdy and comfortable furniture of pleasing design, attractive linoleum flooring, gay posters and, wherever possible, carefully selected and placed forms of fine art, such as reproductions of good paintings, fixed securely in specially prepared niches.

Sufficient modern equipment is necessary for the most efficient functioning of all hospital activities, including treatment, and for reasonable comfort of the patients and staff. This includes such diverse general facilities as adequate plumbing, heating, kitchen equipment and farm machinery and such special provisions for psychiatric patients as an electroencephalograph, physical therapy facilities and an ambulance equipped for the transportation of disturbed patients to the hospital.

Wards should be limited in size, rarely having more than 50 beds, and should have several side-rooms for meeting special needs. Radio earphones, books, magazines, cards and other parlor games should be available on the ward. Areas devoted to acutely disturbed patients should be soundproofed and air conditioning should be provided so that windows can be kept closed. Hydrotherapy facilities should be conveniently available. On open wards, waist-high partitions between beds give a sense of privacy which some patients appreciate, and potted plants and other ornaments can be used.

Village plan for state psychiatric hospital

The physical aspects of the mental health center should be designed along the general lines indicated. Since the state psychiatric hospital is a much larger unit and necessarily includes many buildings, we suggest the following type of "village plan" for its physical organization.

The village should be arranged around a central plaza about the size of a city square block. This plaza should be attractively landscaped, with a bandstand for outdoor music and with benches scattered about among the trees and shrubbery.

The larger buildings of the institution might be grouped facing the four sides of the square in the following manner. On the side nearest the entrance to the grounds would be the administration building, the admission service building, the infirmary and a staff dining hall (containing units for different categories of personnel). On a side adjacent to this group there would be a central cafeteria for ambulatory patients, equipped with portable steam tables to be transported to wards for the sicker patients. This building should be flanked by an inviting barber shop, beauty parlor and soda fountain.

On a third side of the plaza would be the hobby building and the educational building. On the remaining side one would find the building for the community activity unit flanked by play fields and tennis courts. Each of the three buildings of the rehabilitation department should have prominent bulletin boards announcing special activities for patients.

In the area behind the group containing the administration building there should be living quarters for doctors and other personnel. Behind the patients' cafeteria (and connected with it by underground passageways for patients in inclement weather and for the movement of portable steam tables) there should be about 15 separate one story cottages, each housing approximately 100 patients divided into two or three wards, depending upon the needs of the service.

Each cottage should have its own small grounds and the whole group should be so arranged as to be readily accessible to the staff and to the patients' cafeteria. Immediately behind the other two sides of the square should be the laundry, heating plants and garages, and the remainder of the grounds should be devoted to farming and wooded areas for organized walks and picnics.

Other psychiatric hospital services in the community

In communities in which adequate municipal and county facilities for the care of the mentally ill already exist, these should be utilized instead of creating a new state-owned mental health center and should be organized as much as possible in conformity with the concepts outlined for such an institution.

In advocating state mental health centers and improved state psychiatric hospitals, it must be realized that these can serve only a part of the

community needs. Federal hospitals for veterans could be planned along lines described above.

General hospitals should have a psychiatric in-patient and out-patient service. In the less thickly populated districts where other psychiatric facilities are rather far away such a service should be prepared to receive psychiatric emergency cases pending arrangements for admission to the mental health center or to the state psychiatric hospital.

In addition to the advantages of early diagnosis and treatment, more opportunity for research in psychosomatic problems, consultation service and psychiatric experience for the medical community as a whole, Billings notes that such availability of psychiatric service in a general hospital promotes the utilization of psychiatric principles in the medical and surgical wards, reducing therapeutic floundering, shortening the hospital stay for the patient and, thereby, saving the hospital, the patient and the community money.

It is important to note that planning for better public hospitalization of psychiatric patients is not intended to diminish the vital rôle of good private psychiatric care. A small group of institutions supported by benevolent foundations has been of great value to the patients whom it has served and has contributed significantly to psychiatric treatment, research and education. Good private psychiatric hospitals, unfortunately, are limited in number and existing ones usually deny the use of their facilities to qualified psychiatrists in private practice.

What has been said for the further advantages of psychiatric services in public general hospitals holds for voluntary general hospitals. We, therefore, suggest that many more voluntary general hospitals construct psychiatric units in which psychiatrists can hospitalize and treat private and semiprivate patients.

In addition, we believe that more use of psychiatric principles in the practice of the general physician would be encouraged if he were able to admit and treat on such a service some of his patients with not too complex psychiatric problems, provided he has the aid of consultation with a qualified psychiatric staff member.

Participation in medical groups

All psychiatric hospital physicians in the district and psychiatrists in private practice should participate actively in the county medical society to keep abreast of current general medical developments and to aid in integrating psychiatric principles into the thinking of the family doctor. They should also be active members of a local psychiatric association to discuss their common therapeutic problems and to stimulate individual and cooperative research projects.

Further public relations and education

This association, in cooperation with the educational department of the mental health center, the mental hygiene society and other interested local groups, could serve as a coordinator and source of psychiatric enlightenment in the community.

To this end it should provide a program for the general public, including lectures, exhibits of posters and technical moving pictures. It should also provide leadership for public forums for discussion of mental health problems particularly related to the district and the state. These would logically include such a review of the state laws pertaining to the mentally ill as might stimulate the formation of groups to exert pressure for the modernization of antiquated laws.

There would be an interesting opportunity for studying the effectiveness of such a public relations program in the district by conducting periodic polls of public opinion on matters of psychiatric interest in the community. This program could play a vital rôle in arousing a vigorous and effective public demand for and a willingness to pay taxes to support the organization and maintenance of a system of improved hospital treatment of psychiatric patients.

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Auxiliaries "Down Under"

ACCOUNTS of hospital auxiliary activities in America appear from time to time in The MODERN HOSPITAL and as I always read these with interest I thought perhaps the same mental process might apply in reverse—that American hospital workers might care to know something of the activities of auxilaries in New South Wales, particularly as the war has made each of our countries more conscious of the other.

To give you something of the background against which the auxiliaries work, I should explain that New South Wales is a 309,428 square mile state of the Commonwealth of Australia, with a population of roughly 2,790,000. Of these inhabitants, approximately one half live in the capital city of Sydney. About one fifth of the people reside in the larger towns, including the industrial centres of Newcastle and Wollongong-Port Kembla. Less than one third of the population lives in the rural areas.

From One Bed to 1400

Sizes of public hospitals serving the state vary from a 1400 bed hospital in Sydney to 150 bed buildings in the major country towns and down to bush nursing hospitals which may not care for more than one patient. Public hospitals (I shall not be referring to hospitals of any other type) number 210. Each is administered by a hospital board composed of five subscriber-elected members and four government nominees. (In a board of 10 members the proportion of government nominees is four as against six elected by subscribers, and so on, up to a five to seven proportion for a board of 12.)

The principal authority as regards administration of these hospitals is the Hospitals Commission of New South Wales, recently reconstituted by the N. S. W. State Parliament and now composed of three full-time members instead of four unpaid members working part time, as in previous years.

The chairman of the present commission, Dr. A. B. Lilley, is the only Australian to have been elected a fellow of the American College of Hospital Administrators. The commission works within the framework of the N. S. W. Department of Public Health.

The auxiliaries come into the picture as voluntary agencies working for the individual hospitals. They are sanctioned by the Hospitals Commission, which pays the salary of the organizing secretary, and are recognized and welcomed by the hospital boards. Practically every hospital has its auxiliary; many of the larger country hospitals have several, and at least one Sydney hospital has 20 such groups working for its welfare.

Each auxiliary runs its own affairs, has its own officers and deposits the money raised in its own bank account. Rules governing the election of officers and business procedure generally are laid down for all auxiliaries in the "Rule Book of the United Hospital Auxiliaries," which applies throughout the state.

Members must, of course, realize that the money they raise is the legal property of the hospital for which their auxiliary is working and, therefore, there has to be a close liaison between the hospital secretary, the matron and the auxiliary so that auxiliary funds are expended on equipment and amenities which the hospital really requires.

Membership in the auxiliaries is open to men and to women. By far the greater proportion of members are women, but it has been interesting to note that most of the auxiliaries formed in recent months—and such is the "pull" of hospital work that in spite of war conditions new auxiliaries continued to be formed—have wished to have a mixed membership.

In the past, hospitals in New South Wales have been something of a Cinderella as regards finances and although the position is improving hospital boards are glad to have auxiliary help in finding the wherewithal for items varying in importance from the humble cup and saucer to an x-ray plant or a food trolley. Often the commission will pay half the cost of some such purchase when the hospital's auxiliary has raised the other half of the amount, but this is not general.

The methods by which the auxiliaries raise their funds vary a little with the districts but the street stall is favored everywhere and is a sure winner. Baby shows, hospital balls, mile-of-pennies, flower shows, competitions, card and picture evenings, opportunity shops, pet parades—these all find their place in auxiliary programs.

Splendid results come from gymkhanas in outlying centers. These are often concluded with a ball at night, for visitors come from far and near and enjoy a social ending to the day's events. In peace time, tea tents at the agricultural shows are often run by auxiliary members who may thus add three figures to the income of their group. Lunches for those attending sheep sales and auctions are other auxiliary enterprises in country towns.

Kiosks at hospitals, to provide for the needs of patients, their visitors and to a certain extent the hospital staffs, are frequently established by auxiliaries which buy the stocks and staff the kiosks—in one case that comes to mind members raised the money for the erection of the building. Profits may or may not be large from such undertakings but the service to the hospital is undoubted.

Helped Out in Help Shortage

During the war many members added to their voluntary work by "helping out" at hospitals where the domestic staff made sudden departures and left a matron without a cook or laundress. It always struck me as a particularly good example of real citizenship when I heard that some auxiliary worker, probably with all her own chores to do and like as not with some special war-time burdens of a personal nature to bear, cooked or washed at "her" hospital so that the care given the patients did not slump in standard.

War-time shortages and rationings made many difficulties for auxil-

. . I am sure that if the many members of the hospital auxiliaries in New South Wales knew that I was writing this article they would join with me in sending friendly greetings to their "opposite members" in America. It is encouraging to know that your voluntary workers, like ours, have a compassionate and practical interest in improving conditions for those for whom every hospital exists—the patients.

MARGARET WAYMOUTH FRASER
State Organizing Secretary
United Hospital Auxiliaries, New South Wales, Australia

iaries. With tobacco, sweets and biscuit shortages the kiosks found it hard to offer a good range of products; auxiliaries that made jam for their hospitals were handicapped by sugar rationing; butter, tea and meat rationing affected all catering projects; linen gift days suffered because of the coupon question, and yet the over-all returns from the auxiliaries were well up to prewar levels.

Typical Year's Work

One report that was received at headquarters offers a typical example of twelve months' work. It came from Young, a pastoral and agricultural area of about 5000 population. The auxiliary membership would probably be about 20 workers (voluntary workers are not always mindful of headquarters' passion for details and the particular group has not given us recent advice of its membership). During 1944-45 Young auxiliary has aided its local district hospital by:

1. Furnishing the domestic staff lounge room and providing it with a wireless.
2. Purchasing two dozen cups and saucers for maternity ward patients.
3. Providing half the cost of a new wireless installation throughout the hospital.
4. Paying £160 into the general funds of the hospital.
5. Paying £278/8/6 as half the cost of a self-combustion stove.
6. Paying a seamstress to attend the hospital regularly to do renovations.
7. Assisting with the mending of hospital linen.

Members also assisted with the hospital ball and special appeal days and raised £96/10/— to help replace hospital linen.

A great deal of assistance to their hospitals is given by most of the auxiliaries in the mending of hospital linen and in cutting out and making up hospital garments. Two auxiliaries made out a roster and hand-embroidered a marking on every piece of hospital linen (96 bed hospital) in response to a call from the matron who was distracted by the way in which a war-time marking ink was washing out of the linen and confusing the sorting. Members of other women's organizations in the town were also co-opted and in this way a number of newcomers were introduced to the hospital.

Libraries for hospital patients and staffs are another auxiliary activity. At one hospital auxiliary members are assisting the almoner by serving the diabetic patients.

There is a tie-up between auxiliaries and the community through the public and private schools. The school pupils do not belong to the auxiliaries but when the auxiliaries or the hospital boards organize such appeals as "egg days" great assistance is given by the school children in collecting and bringing in the eggs for preserving.

Some schools also hold "market days" at intervals. Then each child brings in one gift—not money—and a grand aggregate of fruit and flowers is sent up to the local hospital.

Hospital Day, as you know it in the States, is hardly worth mentioning here. The body organizing the appeal covers the metropolitan area only. Each city hospital uses its auxiliaries on this occasion but the avenues of the appeal are limited. The country districts make their individual appeals as near to the date of the city effort as possible but seasonal activities may affect their programs and they often have to postpone their functions for some months. Unfortunately, to date no move has been made to coordinate town and country appeals into a genuine statewide hospital day appeal with a date suitable to the majority of hospitals.

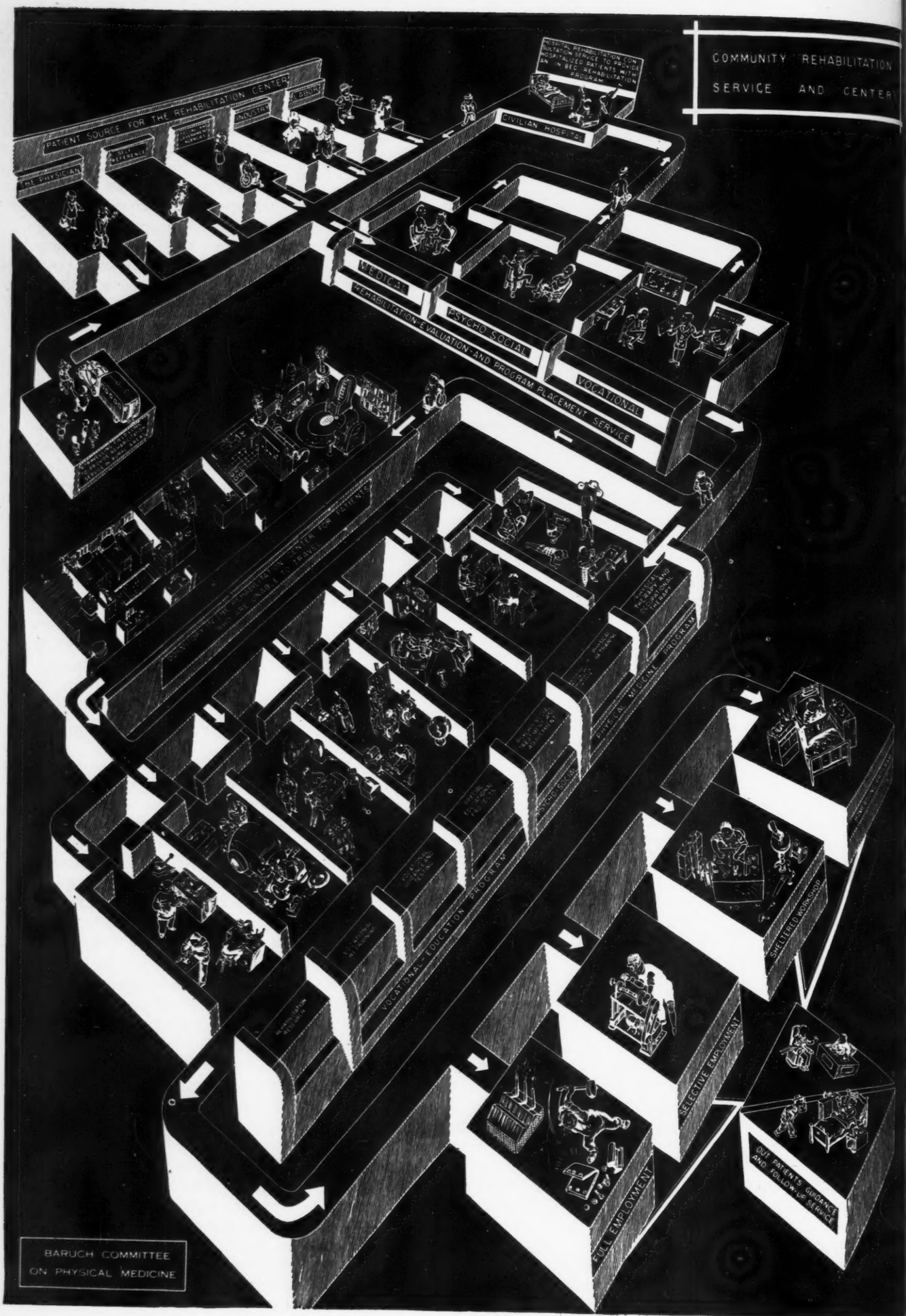
The auxiliaries in New South Wales are grouped into nine regions and regional conferences are held each year (they were abandoned during the war, mainly because of petrol restrictions) and from these gatherings nominations come forward for the central executive of the United Hospital Auxiliaries; elections take place triennially at the annual general conference in Sydney. Last year more than 600 delegates and members, the majority sporting their smart enamel U.H.A. badges, attended the annual conference; the program covered three days.

Meetings Keep Them in Touch

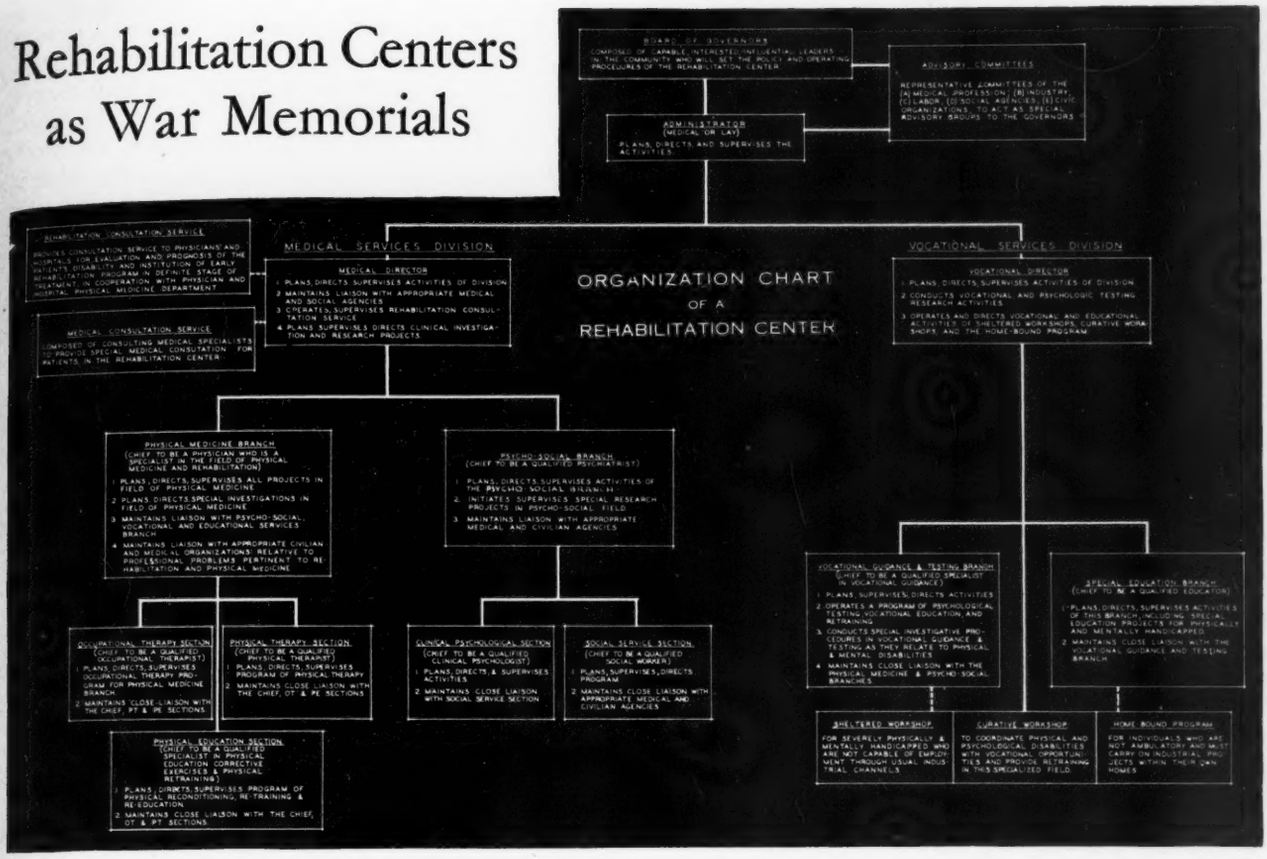
These conferences and visits to the different centers by the organizing secretary keep members in touch with one another and enable them to debate matters relevant to their work and generally to increase their background knowledge of hospital and health matters. Expenses of the conference are met by a five shilling affiliation fee from each auxiliary.

Membership determines the number of delegates which an auxiliary may send and delegates' second-class fares are paid from auxiliary funds. These fares and the five shilling fee are the only monies that an auxiliary may allocate to an object other than the hospital for which it works.

Australia, in common with other countries, is giving considerable thought to the financing of hospital and health benefits generally in the postwar period but so far no scheme has been decided on. Whatever eventuates, it is not likely that the voluntary work done by the auxiliaries will be obliterated.


COMMUNITY REHABILITATION SERVICE AND CENTER
PATIENT SOURCE FOR THE REHABILITATION CENTER
THE PHYSICIAN
CIVILIAN HOSPITAL
MEDICAL
PSYCHO-SOCIAL
VOCATIONAL
REHABILITATION-EVALUATION-AND PROGRAM PLACEMENT SERVICE
VOCATIONAL-EDUCATION PROGRAM
SHELTERED WORKSHOP
SELECTIVE EMPLOYMENT
FULL EMPLOYMENT
OUT-PATIENTS GUIDANCE AND FOLLOW-UP SERVICE
BARUCH COMMITTEE ON PHYSICAL MEDICINE

Rehabilitation Centers as War Memorials



IN ORDER to evaluate the need for a civilian rehabilitation service and center and to blueprint a typical center as to its mission, organization, components, physical setup and relationships, the Baruch Committee on Physical Medicine appointed a subcommittee on civilian rehabilitation centers to study the problem.

The opinions and conclusions of the subcommittee are as follows:

1. There is a crying need for a community rehabilitation service and center program. Large highly specialized urban rehabilitation centers are necessary but are not enough; in order to carry the opportunity for treatment to the isolated disabled, a system of mobile consultant clinics and similar services must be set up in rural communities.

2. Certain activities can be carried on in smaller communities using the facilities that are available, but rehabilitation clinics, geographically located, must be established to carry out the specialized procedures that are necessary for the rehabilitation of the severely handicapped.

3. Rehabilitation service and rehabilitation centers are community projects, and all of the existing facilities and organizations in the community must be fully utilized. The rehabilitation center must be a part of the community rather than a thing within it. It is necessary to know what the community has to offer in terms of personnel and physical equipment.

4. The objectives of a rehabilitation center are physical, mental, social and vocational adjustment; after a period of medical, psychosocial and vocational evaluation, the individual must be fitted into an over-all program designed to accomplish these objectives.

5. In the establishment of any rehabilitation project it must be realized that industry is the keystone of the whole structure because industry must take the finished product and, by careful and selective placement, utilize these individuals within their capabilities. Labor must understand that the third phase of medical care, rehabilitation, is a service and right that must be made available to all citizens in a democracy.

The medical profession, governmental and social agencies, insurance companies and individuals must be made cognizant of the opportunities available in a comprehensive program of rehabilitation.

6. A comprehensive educational program, both professional and civilian, is necessary to the successful prosecution of any rehabilitation service.

Professional: To acquaint physicians, nurses, social workers, physical therapists, occupational therapists, physical educators, vocational guidance counselors, psychologists, educators and all other interested scientific groups with the principles, procedures and results in rehabilitation by: (a) comprehensive courses in rehabilitation (graduate and postgraduate) for physicians, students of medicine, and its allied professions, (b) clinics and demonstrations, and (c) scientific publications and exhibits.

Civilian (Community Education): To acquaint the individual with advancements, possibilities and what he has a right to expect from rehabilitation by: (a) fiction and nonfiction; (b) radio (educational programs and dramatizations); (c) motion pictures; (d) industrial publications, trade journals and similar publications; (e) labor journals; (f) scientific treatises, and (g) cooperation of national organizations.

The accompanying statements on an ideal community rehabilitation center incorporate the preliminary deliberations of this subcommittee. More detailed information will be available later.

Medical Records

Should the house staff be responsible for them?

FRANCES R. STEEN, R.R.L.
Formerly, Medical Records Librarian
Charlotte Memorial Hospital, Charlotte, N. C.

NO ONE suffered more from the demands of war than did the hospitals and the medical profession. Even now from one third to one half of the practicing physicians are in the armed services and sickness and death have not waited for the war to cease, even in civilian America. This has resulted in a tremendous burden being placed upon those remaining at home.

Because of the increased load, civilian physicians and resident staffs of hospitals unconsciously developed a tendency to slight some responsibilities which, in their own minds, may be considered minor. Perhaps the greatest shortcoming is the failure to maintain a complete medical history and record of treatment given to each patient.

Too many doctors have allowed these incomplete records to accumulate with such pleas as "I'm too busy to bother with charts," or "How can I complete these records when I still have so and so many patients to see tonight?" But busy or not, there is another side to the picture.

No Record, No Fee

It has been aptly said that a physician is duty bound and morally obligated to complete the medical history and physical examination, record of treatment and summary of a case before he is entitled to collect his fee from the patient. Perhaps some physicians may be shocked at this statement, but if it is analyzed from the point of view of modern medical practice one can readily see that a complete record must be kept if a patient is to receive the greatest service from his present physician or any new man he may visit.

Even before the war it was difficult enough for a doctor to remember every detail of each case, and with the present number of patients it is a physical impossibility today. Then, too, a patient may outlive his physician and in such case, unless complete records have been kept, the patient, not being medically educated, is unable to provide accurate details of his past treatment for his new physician.

Too often these medical records are not written while the treatment and care given are fresh in the doctor's mind, and when he attempts to write it a week or three months or six months later, he remembers little or nothing about the patient or worse, he fails to write anything.

Another factor that cannot be overlooked is that a number of our civilian physicians have taken over patients for doctors who are in the armed services and it is their moral responsibility to prepare complete medical records for the benefit of the service-connected doctor when he returns to take up the care of his patients again. These physicians in service, practicing under the stress of war, have, as we all know, made medical history. But when they return to civilian practice, they are going to be particularly interested in research and scientific developments in diagnosis and treatment. In addition, these physicians will require a period of graduate medical education before reopening civilian practices.

Can these things be done without good medical records? Suppose, for example, a physician decides to make a study of cancer of the liver over a twenty year period. Of what value would it be if there were a long gap while a war was being fought? Unless all records on such types of patients have been completed properly, either by himself or some other attending physician, his study will result in relative failure.

Most hospitals agree with what has been said as to the importance of records and make desperate attempts to obtain the proper cooperation from their medical staffs to keep records complete. However, in the larger hospital, in many cases, the work falls almost entirely to the resident and intern staffs. Here one meets the same difficulty. The house staffs of most hospitals have been reduced from one third to one half and the remaining men, with their increased burdens, feel that they do not have time to bother with records.

This was the case at Charlotte Memorial Hospital, Charlotte, N. C. The intern committee and the administrator had some reservations as to whether the resident and intern staffs *could* be expected to keep these records complete along with the additional demands made upon them.

To find the answer, a questionnaire was prepared by the medical records librarian. It was sent to 75 nonteaching general hospitals, ranging from 250 to 350 beds, throughout the United States. Fifty-two hospitals responded, but eight were later found to be connected with medical schools and were therefore eliminated from the list.

It Is a Live Problem

In view of the deluge of questionnaires today, the fact that 70 per cent of the hospitals answered this one surely indicates a lively interest in the problem. Does it mean that other hospitals have had complaints from their house staffs and that the work is not being done satisfactorily?

There follows a tabulation of answers to the questionnaire which helped us with our problem and may also be of aid to others.

1. Are interns and residents required to write histories and physical examinations on all patients? If so, how soon must they be completed?

2 hospitals do not require this.

5 hospitals require this only on ward patients or on approximately one half of the patients admitted.

37 hospitals do require this.

Immediately on admission	2—05.4%
As soon as possible	2—05.4
Within 24 hours	26—70.3
Within 48 hours	2—05.4
Before discharge	4—10.8
No time limit given	1—02.7

2. Are interns and residents required to write progress notes on all patients? If so, how often on acute cases and how often on chronic cases?

4 hospitals do not require this.

7 hospitals require this on staff cases.

33 hospitals require this on all patients.

Acute cases	
As often as patient is seen	1—03.0%
As often as necessary	7—21.2
Daily	18—54.6
Every 1 to 3 days	5—15.2
Weekly	1—03.0
No time given	1—03.0
Chronic cases	
As often as patient is seen	1—03.0%
As often as necessary	7—21.2
Daily	1—03.0
Every 2 to 3 days	15—45.5
Every 3 to 5 days	3—09.1
Weekly	5—15.2
Monthly	1—03.0

3. Are interns and residents required to write a history of all operations at which they assist?

23 hospitals do not require this.
16 hospitals do require this.
5 hospitals require this on staff cases only.

4. Do the interns and residents dictate these sections of the medical chart to a medical secretary or a dictating machine or do they write them by hand?

In 18 hospitals the interns dictate all their notes.
In 19 hospitals the interns write all their notes in longhand.
In 5 hospitals they do both (approximately half and half).
2 hospitals did not answer this question.

5. Do you have an out-patient department? If so, approximately how much time does each intern spend in it?

29 hospitals have out-patient departments in which the house staff spends a varying amount of time.
15 gave definite hours, averaging two hours daily (high, 4 hours daily; low, ½ hour daily).
9 classified it as a definite service.
5 hospitals gave no definite time.

6. Who is responsible for seeing that these items are accomplished?

There seemed to be little consistency in the replies to this question, the answers varying widely. However, nine hospitals, or 16 per cent, appointed their head resident or resident staff accountable for seeing that records were completed; and 12, or 25 per cent, of the hospitals delegated the responsibility to their intern committee which based its actions on reports of the medical records librarian.

Other hospitals relied on combinations of the following groups of individuals: intern committee, records committee, medical records librarian, chiefs of services, attending physicians, special committees, "adviser" and medical board. In all cases, naturally, the final authority reverted to the superintendent of the hospital.

The 44 hospitals included in this tabulation had a daily average of 25 admissions, with a high of 46 and a low of 15. The house staffs of these hospitals averaged a little over eight, the highest number being 19 and the lowest four.

It will be seen that 84 per cent of the hospitals require the resident staffs to complete all "histories and physicals," the part of the medical chart that requires the most time to finish. If the house staffs of 84 per cent of this cross section of hospitals picked at random are able to complete the increased number of medical records allotted to them and still keep up with other duties, then it may reasonably be assumed that the rest of us *can* do something about it!

Administrative Axioms

E. M. BLUESTONE, M.D.
Director, Montefiore Hospital, New York City

INMATES of independent hospitals for chronic diseases may be grouped in accordance with an A B C classification. Group A consists of those patients who belong in a general hospital; group B consists of those patients who can be cared for at less expense, under the supervision of the hospital, in their own homes, and group C consists of those who require only custodial care which should be given in an institutional home rather than in a hospital.

THE DISCHARGE of a patient from a hospital should never be permitted to become an acute episode in his life as it may have been when he was admitted. The urgency of discharge is not equal to the urgency of admission, unless you conduct the only hospital in town and a desperately sick patient is waiting for the bed.

THE "CHRONIC" patient derives his adjective from the original Greek "chronos," meaning time, and he is still serving time in our institutions today. This is particularly true in those "hospitals" which provide him with custodial care only.

AMONG some of the curiosities in our hospital dictionaries which will some day be held against our generation and which are still heard in our hospital assembly halls are the following:

A "custodial patient" is identified by the hospital executive through the fact that he does not require intensive medical care in a hospital. Not so by many clinicians. According to some surgeons, a custodial case is one that does not require a surgical operation. According to some physicians, he is a patient who does not respond promptly to any kind of medication known to the visiting staff.

An "acute patient" is one who is not chronically sick and a "chronic" patient is one who is not acutely sick, and so it goes. None of these definitions gets us anywhere, but most people seem to think them plausible. There is, of course, no difference between the "acute" patient and the "chronic" patient from the point of view of hospitalization, except that the former must get priority on available beds because of urgency.

PHILANTHROPISTS may be selective in their humanitarian instincts, but philanthropy itself, by the very origin of the term, is nonsectarian.

YOU CANNOT transfer the charitable impulse from the individual to the community. Men who have charity in their hearts will continue to give long after the state will have taken over the last of our voluntary hospitals.

FAR FROM being an undesirable residue discarded by the mill of the general hospital, the long-term patient is precious clinical material for the man of science. He is under control over comparatively long periods of time and deductions made from the treatment of his condition are therefore more likely to be reliable.

NEVER place an obstacle between the patient and his physician and remember that distance is an obstacle.

Chronic Disease
From a Patient's Point of View

ELEANOR McCLURKIN
Aledo, Ill.

TO ASK a disabled person to describe what he deems necessary in home or institutional care is like asking a man what he wants in a wife. Opinions are colored by personal desires and experience, by education and social background.

In this study I am considering the disabled adult classified by Inez M. Carpenter as the "tertiary cripple," that is, one incapacitated after formal education is completed and physical growth is attained. He is usually financially independent at the time accident or disease strikes and may even have dependents. I am giving major consideration to those who cannot be fully rehabilitated.

What Lies Ahead for the Patient?

Whether the disability is caused by chronic disease or accident is not essential to this study because results are frequently the same. When the first stage of acute illness and treatment ends, what lies ahead? Further care in the general hospital is usually discouraged, and far too often there is no family willing or able to care for the patient.

Dr. E. M. Bluestone, director of Montefiore Hospital, New York, advocates a radical break with tradition in order to plan a complete community program for the long-term patient. He advises a general hospital for acute illness and emergency surgery; a hospital for treatment of chronic diseases and orthopedic cases; a custodial home for the permanently and seriously disabled. These, he believes, should be one medical center under the same supervision.

This well-planned unit would give excellent opportunity for medical research. It would also enable the long-term patient to use the facilities of hospital equipment when necessary. Yet it seems to be planned for the urban community and requires a centralization of institutions where overhead costs are highest.

The destitute and maimed welfare cases in rural areas are perhaps the most neglected of all. When county homes or almshouses accept cripples their untrained personnel is not equipped to give proper care. Supervisors are sometimes able to obtain care in private homes but the limited funds at the supervisor's disposal make it impossible to find the best type of foster home.

However, it seems an unwarranted expense, which the taxpayer would not countenance, to send all these cases to a city medical center. Aside from financial considerations it seems unwise to remove such patients from their locality and friends.

It would be impractical to plan institutional care in county units. In his book, "The Unseen Plague," Dr. Ernst Boas estimates that hospitals for chronic disease should contain at least 100 beds, for smaller units mean greater expense per person.

Many rural counties have cooperative arrangements for sanatorium care of tuberculous patients. It seems that a practical method of caring for other chronic diseases could be planned on the same basis. In my home county, Mercer in Illinois, taxpayers voted a mill tax for tuberculous cases. Patients requiring sanatorium care have a choice of several institutions in adjacent counties. Clinical examination, home care of incipient cases and educational and preventive activities are supervised on a county basis.

Such a plan for the less spectacular and noncommunicable chronic diseases would require more publicity on present needs. It also calls for proof that community health would benefit by establishing centers for care and study of crippling diseases.

In many instances the health values for the patient in rural institutions would offset the convenience of centralized city units. A rural health center of this type could serve many community needs. And if adequate grounds were provided many patients could help maintain them.

I am thinking of the possibilities of gardening, poultry and dairy farming, small fruit farms and orchards as therapeutic aids in rehabilitation. Many individuals have found these activities possible in spite of their crippled condition. There should be further experimentation and demonstration of these activities as a source of support for disabled rural citizens.

This may be a good time to agitate for experimental centers of this type under private or public organization. With the reconversion of government lands and buildings to peace-time uses it may be possible to find suitable sites for this purpose. It will of course require careful planning and initial expenses may seem large to the inexperienced.

Public Is More Responsive Now

Owing to the great increase in war-created disabilities the public is more open-minded to our needs. Thought provoking articles in popular magazines have shown greater possibilities in rehabilitation. Such articles are designed to prepare the citizen to cooperate in assimilating disabled veterans in community life. Perhaps this is also the psychological moment to present the civilian's case to welfare agencies and individuals.

Two of the chronic diseases with the highest mortality rate, tuberculosis and diabetes, have proved that treatment is not enough. Those who want to live must be taught how. Consequently, education to that end is stressed as much as treatment.

Although actual life is not at stake in all chronic diseases many serious complications and crippled conditions could be avoided by a new conception of the hospital as an educational institution.

Dr. Alfred E. Phelps in "Your Arthritis" admits that one difficulty in evaluating treatment for this preva-

I wish to thank the following for their advice and encouragement: Edna Nicholson, director of the Central Service for the Chronically Ill; Mrs. Thomas D. Rambaut, secretary-treasurer of the Shut-In Society; Edgar T. Stephens, executive secretary, Illinois Association for the Crippled, also Lillian Dowdell, librarian, bureau of information, National Society for Crippled Children, for her invaluable aid in research, and many disabled friends for their helpful suggestions.

This is frankly one patient's considered opinion of the needs of the sufferer from chronic disease, but I have tried to view it objectively as only one of a multitude

lent disease is lack of statistics. Scarcity of funds makes compiling data and follow-up of cases impossible. Therefore it seems imperative that facilities should be made available for the chronically diseased.

There are 100,000 free beds provided for tuberculous patients in the United States and $100,000,000 is spent annually to care for patients with this disease. Yet arthritis, only one of the chronic diseases, has only $200,000 to cover research and treatment. Although not communicable it produces more invalids than does tuberculosis.

Army Shows the Way

Army hospitals are working out new technics in rehabilitating servicemen. They find it best to begin reorienting the patient at once. Light exercises, mental occupation and recreation begin as soon as possible. All facilities are coordinated to reeducate the seriously disabled. Recovery and readjustment to life are greatly hastened by this plan.

The civilian patient faces a similar shock and readjustment which frequently are overlooked in treating physical symptoms. Mental attitudes must also be considered. Adequate diagnosis is the first essential and the treatment must cover as long a period as necessary in the hospital.

If former living or working conditions are a contributing factor, however, the patient should be prepared for different activities while undergoing treatment. This means a much broader conception of occupational therapy than the present general hospital provides. New skills can be gained that have both therapeutic and educational value. But mental as well as physical needs must be considered. The patient will cooperate in the most tedious repetitive activities for muscle building if they are fitting him for a useful job later. Cooperation with state employment and rehabilitation agencies will be a part of the integrated program. With some of the insecurity and worry over loss of job and income removed, the patient should respond faster to treatment.

In the hospital that is geared to longer periods of treatment, the staff undoubtedly will develop greater personal interest in and a more informal attitude toward patients. It will miss a great opportunity if capable well-educated patients are not enlisted in research projects.

It would encourage the educated patient to feel that there were openings for his previous training. Frustrated problem patients might disclose their worries to one who had been "through the mill" when they distrust an able-bodied counselor. "Ward life" often discloses this tendency. I have seen uncooperative patients aroused by a "bull session" or by thoughtful advice from a more experienced roommate.

Contacts with other patients will form a valuable part of this educational program. Common problems faced and congenial friends widen interests and prohibit too much introspection. Participation in social activities should be encouraged. All of these should reduce self-consciousness when the patient returns home.

Self-reliance will be increased by instruction in the care and safeguards necessary to keep well. Responsibility for gullible cure-chasers, neurotic food faddists and gadget buyers frequently can be placed at the exit door of the general hospital. The patient leaves with a list of don'ts which only bewilders him. A constructive program while in the hospital would change that picture.

Let dietitians in the chronic disease hospital do more than feed the faces of the patients. Nutrition classes could be planned to teach different groups. This would serve a fourfold purpose: (1) furnish statistics on diets best suited to certain diseases; (2) establish better eating habits for the patient; (3) eliminate some of the mealtime "crabbing" common in institutions, and (4) fortify the patient's resistance to the amateur prescribers he meets. Of course, fanaticism and belligerence should be avoided and common sense and good-humored acceptance of restrictions should be emphasized in discussing diet.

One of the crying needs of the home-bound patient today is for information and guidance in the selection of appliances for home exercise. Few of us ever see a physical therapist and must devise our own gadgets. Commercial appliances often need special adaptation or are financially out of reach.

The physical therapy department could render valuable aid in testing appliances and in adapting simple devices to home conditions. Clinical demonstrations for doctors and nurses would enlarge this service for slight injuries treated in the home.

Follow-Up System Essential

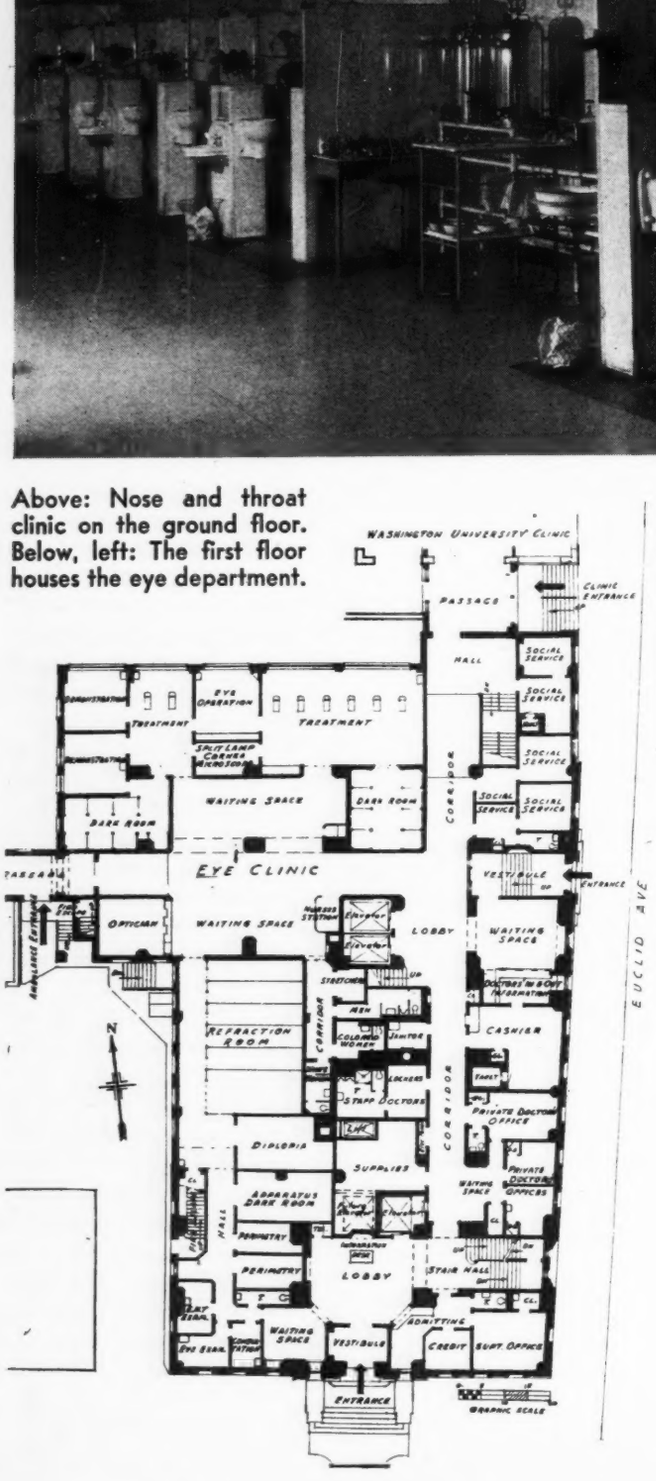
Out-patient clinics and a follow-up system should be part of the hospital program. The patient who knows he can return for checkups in case of recurrence of symptoms will have one great fear removed. For a common worry among us is "What will happen if I get worse?" This fear is responsible for morbid preoccupation with symptoms. With this removed a healthier attitude can be developed.

It will be necessary to establish connections with the patient's home some time before dismissal. Even if ultimate physical recovery is ruled out, hospital gains may be wiped out by improper home conditions. Through the medical social worker the home situation can be studied. Conferences with members of the hospital staff can be arranged to make sure that the family understands the patient's needs.

The patient, too, must be prepared to adapt himself to family conditions and assume the responsibility for his conduct. For it is not fair to unload a problem patient on a family that is ready to cooperate.

This brings us to the patient who is ready for dismissal but has no place to go. He may have no home yet be unable to care for himself, or his family may be unable or unwilling to assume responsibility for proper care of an invalid. The concluding sections of this study, to be published in forthcoming issues, will deal with that serious difficulty for the cripple of today and with suggested types of homes and settlements.

Above: Nose and throat clinic on the ground floor. Below, left: The first floor houses the eye department.



Below: Plan of the ground floor showing the layout of the ear, nose and throat treatment rooms.

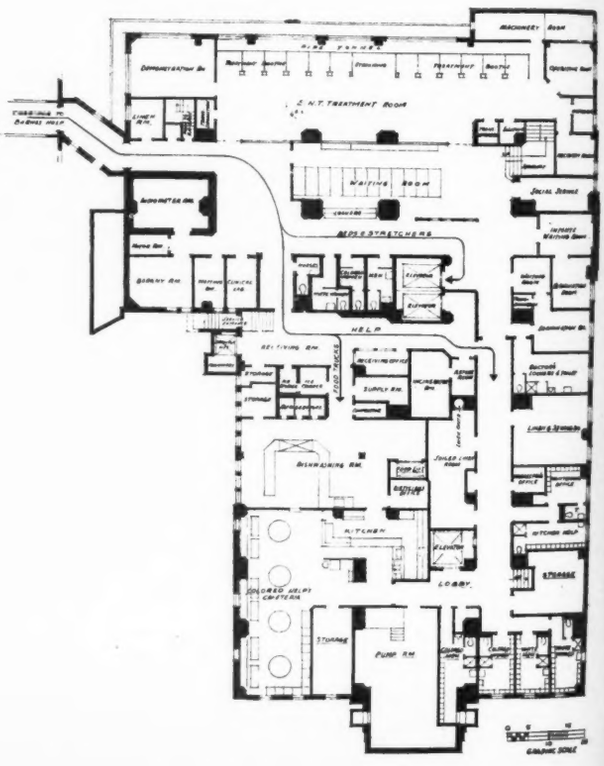
McMILLAN HOSPITAL ST. LOUIS

CORNELIA S. KNOWLES, R.N.
Assistant Superintendent
Barnes Hospital, St. Louis

JAMIESON and SPEARL
Architects, St. Louis

McMILLAN HOSPITAL, St. Louis, was designed to serve as part of the Barnes Hospital-Washington University Medical School group. It contains complete facilities for the care of eye, ear, nose and throat, and psychiatric patients, supplementing the general hospital services in the rest of the group—general surgery, general medicine, obstetrics and pediatrics.

In addition, McMillan has complete clinic facilities for eye, ear, nose and throat patients with minor operating rooms, treatment and dressing rooms, darkrooms and soundproof audiometer room. The Oscar Johnson Institute for Medical Research is a co-occupant of the building, occupying the upper five floors.



CONSTRUCTION DETAILS

CONSTRUCTION: The building, a 13 story structure with basement, of reenforced concrete, fireproof construction throughout. Exterior walls, brick masonry with cut stone trim; windows, wood except for metal as necessary. Interior walls, Vermont marble and plaster; ceilings, plaster painted light tan. Interior partitions, hollow tile and plaster. Stairways, concrete throughout. Bedrooms have different color schemes. All bedrooms have direct access to baths and toilets, and all toilets off private rooms are equipped with bedpan washers. Each floor has a complete general utility room with small auxiliary rooms off corridors to avoid unnecessary walking.

Bedrooms for disturbed psychiatric patients are equipped with escape-proof screens, double sash to make rooms more nearly soundproof, louvered shades to prevent patients from looking into or being seen from Maternity Hospital to the west, flush lighting fixtures and complete automatic air conditioning (heating, cooling and ventilation), thus making it unnecessary to open windows except for cleaning them. Ceilings on neuropsychiatry floors have acoustical or soundproof treatment. The top floor of the building is arranged for occupational therapy and is equipped with escape-proof screens.

WALLS: Corridors, lobbies and waiting spaces except in portions of the third and fourth floors (neuropsychiatry), marble wainscoting. Operating suite, toilets and baths, ceramic tile wainscoting. Diet kitchens and utility rooms, quarry tile wainscoting.

FLOORING: Patients' and interns' rooms, asphalt tile with asphalt tile base. Corridors on bedroom floors, terrazzo border and base and asphalt tile fields. Operating suite, toilets and baths, ceramic tile. Diet kitchens, utility rooms and day rooms, quarry tile. Entrance lobbies, ground and main floor corridors, clinics and public spaces, terrazzo.

ELEVATORS: The building was arranged to have three high-speed passenger elevators, a service elevator and a food lift, each with full automatic push-button control. Owing to war conditions, one passenger elevator could not be installed. Elevators near patients' rooms have swinging instead of sliding doors to give maximum quiet.

CALL SYSTEM: Electric 'in-and-out" system for doctors, with main panel at east entrance to building and sub-panels at each nurses' station; "silent-call" paging system operated from main floor with call boards at nurses' stations and in corridors.

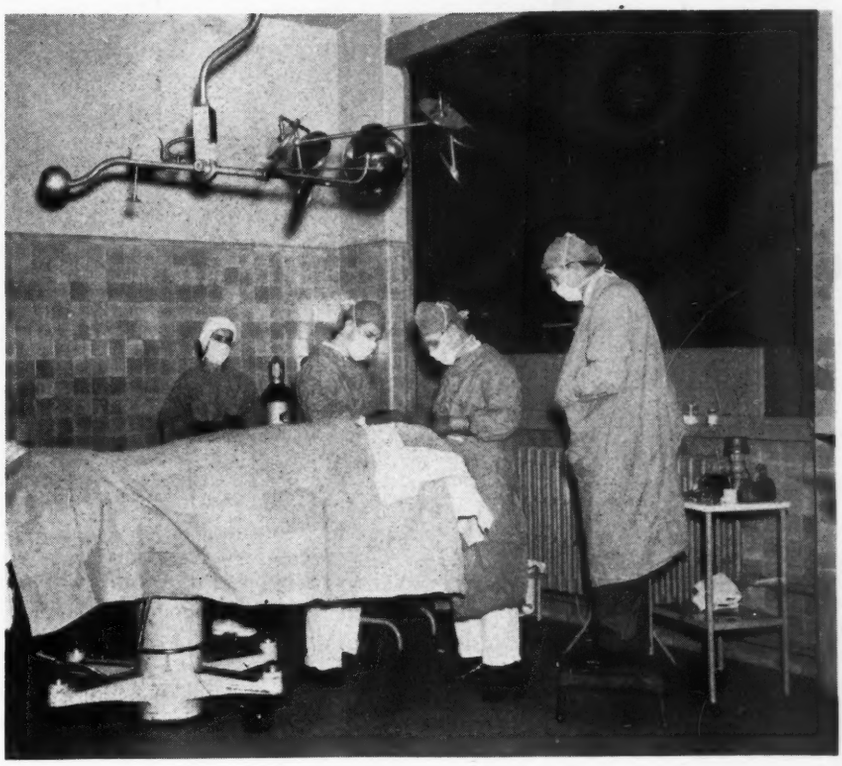
LIGHTING: Corridors throughout the bedroom floors have small flush louvered nightlights to illuminate floors only for night work. Bedrooms are equipped with high and low intensity lighting units.

VENTILATION: Both clinics, cafeteria and all interior toilet and utility rooms have mechanical ventilation. Special rooms for disturbed patients are air conditioned. All patients' rooms have ventilators in lower rail of window sash admitting fresh air without draft.

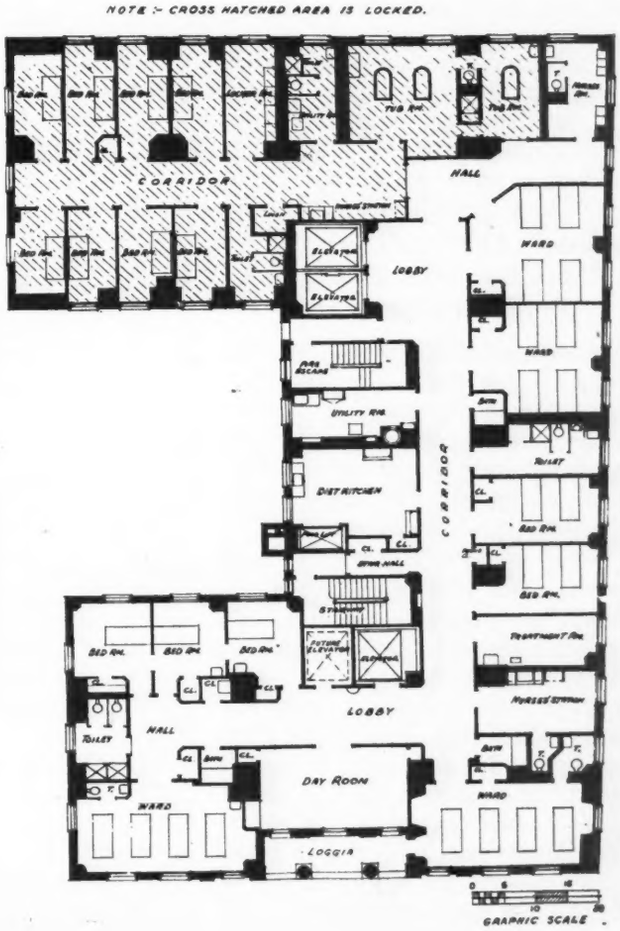
HEATING: Direct radiation with thermostatic control except in private bedrooms where local control of each radiator is provided. Steam is generated at central heating plant.

REFRIGERATION: Basement refrigerators are cooled by brine pumped from main power house. Refrigerators in diet kitchens and utility rooms are self-contained electric units.

COSTS: The building contains a total of 1,874,000 cubic feet, of which the Oscar Johnson Institute occupies 714,100 and the hospital, 1,159,900. The cost of the building was $1,510,875 of which $633,691 was for the institute and $877,184 for the hospital. The cost per cubic foot was 88½ cents for the institute and 76 cents for the hospital. The cost per hospital bed (160) was $5482. This cost includes all laboratory, clinic and hospital equipment, mechanical, heating and electrical equipment and apparatus, architects' and engineers' fees and contingencies.



Above: Eye operating room at McMillan Hospital, showing the close-fitting black shade that completely eliminates natural light. Right: The building also houses a psychiatric unit. The plan shows one floor (the third) of this unit. Note that cross-hatched areas are locked. Ceilings on the neuropsychiatry floors are soundproof. Windows are escape-proof.



Public Address System

Another Aid to Good Public Relations

MAJ. S. J. JOHNSON, SnC
Station Hospital, Camp Gruber, Okla.

NO DOUBT many hospitals that are now planning new buildings and equipment are considering the possibility of installing bedside plug-in radio systems. Such equipment would have ear phones or speaker pillows in the wards with the option of regular loud-speakers in a private room. This idea, I know, is not new nor is it the purpose of this article to discuss the advantages or disadvantages of such a bedside radio system.

Instead, I should like to suggest an extra channel or outlet to be used in such a radio system. This channel's broadcast would issue from a central control room in the hospital, *i.e.* the chapel or administrative office. This outlet would be the public address system. Its purpose would be to supplement regular radio programs in a more personal and intimate way.

They Don't Have to Listen

Although this idea may not be found in the usual conception of a public address system, yet it is the same in principle without the disadvantage that all patients and hospital personnel alike must listen whether they want to or not.

How would this channel be used to aid public relations? Let me present a few personal ideas and those obtained through my experience in Army hospitals.

In the first place, all programs (other than those designed for therapeutic purposes and for special wards or floors) to be given over this channel should be published well in advance so as to give interested patients an opportunity to listen, and the schedule should be planned whenever possible so as to prevent the interference with major network programs of great interest and appeal.

The specific uses of such a channel are many and varied, depending largely upon the nature of the hospital and its size. For example, there can be a story hour for the little patients in the pediatric department. Every nurse well knows the problem of quieting the children for the night. What a boon it would be if these patients could look forward to a story hour before bedtime every night and how much better they would sleep once their restlessness was gone.

The channel could also have a great therapeutic value in the psychiatric department where the benefits of music therapy are now being investigated and judged. This phase of psychotherapy is admittedly in its infancy but cannot be overlooked in the hospital because its initial value has already been recognized.

There are also instances when celebrities and nationally known persons visit the city. They could not be expected to visit each patient individually. Time usually prevents this, nor is it practicable. However, almost without exception, they could find a few minutes during their visits to speak to all patients over the hospital's own channel from the central control room. No one would then feel slighted or be disappointed and the general morale of the patients would be effectively bolstered.

Another possibility would be scheduled talks by the hospital administrator or his representative. Such talks could be daily or biweekly, or as often as time would allow, and could be the means of informing the patients about hospital activities, incorporating any bits of personal news that might be of interest to all.

In most instances, the hospital administrator loses personal contact with the patients owing to the volume of his work and the demands upon his time. Although the radio talk is still a substitute, it is nevertheless better than no contact at all and would tend to personalize the hospital's atmosphere, making each patient feel a more important part of the unit as a whole.

There might also be a period of recorded music during the lunch hour and an all-request program of dinner music, naming the patients who requested the numbers. This program could be classical or popular, depending upon the needs, or a set period of time might be allotted for each type.

Along this line, one might bring in local talent, such as high school glee clubs, playlets by local dramatic clubs and church choirs. Even talent within a hospital could be organized among ambulatory patients, if so desired, with no end of variety to the entertainment possible.

Broadcast Religious Services

As a last suggestion for the use of this channel, there are the important religious services. In our hospitals we have patients of all denominations, many of whom do not like to miss Sunday services. If the hospital has a chapel there could be a direct pick-up from the chapel, making the services available to all bed patients who wish to participate. If there is no chapel, the local ministers would undoubtedly be more than happy to come to the hospital and broadcast their services from the central control room. Special programs could be arranged for important religious holidays as well, such as Christmas, the Lenten Season or the Jewish New Year.

The same system could be used for audible paging by those hospitals that prefer this type of paging or, perhaps in emergencies when the entire hospital staff must be immediately notified. However, for the most part, I think of the channel as being primarily an aid to the patient's welfare and well-being and as a means of hastening and easing his recovery.

The NURSE

link between patient and doctor

RICHARD D. LOEWENBERG, M.D.

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AFTER working for twenty-five years on three continents in general, religious and industrial hospitals, it is fascinating to review some typical experiences of group interactions among patients, nurses and doctors which reoccur independently of time and place.

Confining ourselves to the life of the hospital in action, let us ignore the ever-present personal problems of each nurse and doctor, which change with the individual, and concentrate on the unique position of the nurse under the cross-fire of patients and doctors. Let us try to diagnose some of the disturbed group interactions by means of modern medical psychology.

Emotional Forces Ignored

Medical science pioneered in the removal of irrational fears about epidemic diseases. Can we any longer afford to ignore the forces within us and our patients? The technical advances in the construction of hospitals have been amazing during the last decades; must we lag behind half a century with the better organization of the emotional forces in hospital life which determine to so great an extent the outcome of our efforts?

Psychosomatic medicine, the newest catchword for the idea that form and function are inseparable, is a rediscovery known to old medicine. Its immediate, practical application can be observed every day on the wards because all treatment measures are both psychologic and physiologic.

Many physically healthy people are invalids and a great number of chronically sick are full-fledged wage earners. Thus, this should cause us to be doubly cautious with the popular phrase: "there is nothing physically the matter with you; snap out of it," as though it is just a matter of personal decision to be ill or not.

Finally, even before we start any form of treatment, we are faced with misconceptions in the minds of our patients, which cause so much tenseness. Similar symptoms are taken for diseases, identical therapy is expected for conditions that outwardly look alike and no allowance is made for time and patience in this era of high speed.

Thus, one might say even before the curtain rises that, in spite of the best technical training, the nurse finds herself thrown into an emotional turmoil of attitudes, counterforces and interferences from the outside that find a much deeper echo within her own conflicting emotions than she realizes.

The puzzling attitudes of patients toward the nurse from the very beginning can be understood only by considering their upsetting experience at the time of admission, which is colored by the patterns of their past life story.

People who work in a hospital for years too often forget the public's aversion to its very walls, within which so many people are sick and die. The significance of having to go to a hospital is a great incision in the patient's routine. It is a kind of feeling expressed by one of my surgical teachers when operations did not succeed. He used to comment: "the beautiful security of everyday life is shaken."

Thus, every patient feels his existence threatened. Even when we do not consider his condition especially serious, every injury or disease is dead earnest to him. Therefore, he will deeply resent any humor or joking, no matter how harmless it may seem to the nurse. For the same reasons, even when the patient is only semiconscious, any medical remarks about his condition should be expressed with utmost caution. His whole present situation, to say nothing of his lack of training, makes him susceptible to unfortunate misinterpretations.

Rapport Is Established

When the fears and apprehension of the first days of hospitalization have subsided, those factors that developed from the life story manifest themselves more clearly in the interrelationship. The establishment of a rapport, good or bad, is unknowingly predetermined.

Confining myself to a minimum of analytical terminology, I have to mention the ever-present forces of transference. As the word implies, it means the carrying over of our emotions from one object to another, in both a positive and negative sense. This universal tool for adjustment springs from our original relationships to our parents and repeats itself on different levels in our atti-

Address to the nursing staff of Kern General Hospital, Bakersfield, Calif.

tudes toward teachers, friends and superiors.

The patient in his isolation projects all his positive and negative emotional feelings into the physician and nurse. Love and hate, repressed anxiety and feelings of guilt may flare up and result in unpredictable outbursts out of proportion to reality. To be sure, such serious reactions occur only occasionally.

In the majority of cases, these displaced emotional attitudes appear in the disguise of overobedience, touchiness or seclusiveness. A kind of shadow-fighting of revived past experiences occurs in the present situation. This struggle, however, is not identical and not quite as real and permanent as were the original emotional attachments.

Relatives Are the Problem

Only insight into these forces can bring us to a sympathetic handling of these situations. It is the experience of most nurses that eventually one can succeed with most patients but rarely with their relatives. Their disappointments and frustrations discharge themselves at the bystanders.

The public rejects tablets, poisons, injections and surgery, insisting on oversimplifications and believing that doctors are manufacturing diseases. People find it hard to think outside of extreme alternatives.

Finally, the relatives jealously resent the nurse as an intruder. Every nurse has seen the wailing wall of relatives enclosing the patient and confusing him. They make the visiting hour an ordeal by their anxieties and questions of "please tell us the truth," as though a secret conspiracy were working against them.

The task of the nurse in face of so much turmoil requires more than idealism and sweetness of heart. As nothing is more harmful than active ignorance, she must weigh carefully every word of the information to which the relatives are entitled. The public has most definite ideas about medical problems.

"Ignorance doesn't mean not knowing, but knowing so many things that ain't so," said Artemus Ward. This tendency accounts for the common observation that the nurse's concrete explanations are transposed by the relative into meaningless, foreign words. If she mentions, for instance, symptoms resulting from the development from childhood to womanhood, she is interrupted with, "You mean adolescence."

Also, it should not be forgotten that many older—even nonregistered—nurses are gifted with a natural maternal instinct, undisturbed by too much conscious insight. They succeed marvelously sometimes with excited patients after the psychologically schooled doctors may have failed.

There is no doubt that doctors also have been unknowingly guilty by suggesting diseases to the patient's mind through loose terminology, such as soldier's heart, weak stomach and high blood pressure. One cannot go wrong in avoiding terms like cripple, screwy, insane, nervous breakdown, acid indigestion, will power, "snap out of it" and "pull yourself together."

As no one talks himself into his diseases, no one can talk him out of them. If it were as simple as that he would have done it alone. Experience will make the nurse much more cautious about snap judgments and advising changes in conduct. That should be left to the popular radio programs with their enviable cock-sureness.

The nurse is also under fire from the overstrained, often impatient doctors, who are torn apart by innumerable requests and trifles. Although they have a scientific interest as a safety valve, the nurse feels the full pressure of their worried responsibility in grave and obscure cases.

There she is, a lightning rod, attracting abuse from all sides. A great amount of steadfastness and resourcefulness is required to keep up her mission, to reconcile, to repair again the often broken chain of interrelationship between patient and doctor. But the nurse, as the most important link, has no other choice.

Must Cultivate Outside Interests

Not to get too much involved, how can the nurse still keep an open mind and heart for the suffering around her? Deeply religious persons have a great emotional advantage of being embedded in the unshakable security of their faith; they enjoy the comfort denied to most of us. But everybody should cultivate his zone of privacy to refill his own resources.

According to one's individuality, his form of relaxation, rest, sports, interests in art and work will be different. The important thing is that he has a field of activity different from his hospital duties. Stability does not mean to do nothing but to restore one's balance by activities different from one-sided professional duties. As there are quite different atmospheres in a medical ward or a surgical or pediatric ward, a change from time to time should not be restricted by rigid rules but should be encouraged.

As was previously mentioned, any joking with the patients about their illness should be avoided. However, a sense of philosophical humor on the nurse's part might make more bearable the wear and tear of everyday annoyance.

If the nurse can only take a curiously detached view at times and ask herself, "Why must they be so mean; what will come next?" she will be better able to transfer her own calmness, which comes from competence, to her patients. Emergencies prepared for are no longer emergencies.

Saves Many Sore Spots

If the nurse will put herself in the patient's place; if she will recognize his loneliness as he suffers and is disappointed, she will have no longer to wait for advancing confidence and kindness. It makes no difference whether she thinks he deserves it or not, each of us needs more love than we deserve.

The word "sympathy" means literally "to suffer with" and was well compared by a Texas doctor to the air of the inside of a tire, "There may be nothing to it, but it eases many a jolt and saves many sore spots."

In a war-torn world, a hospital community might be an oasis in the desert of mental and physical devastation, as a human way of life. Our duty is not to inflict wounds but to heal wounds. Color and creed do not count, nor do race and rank. Science is the only really international field of our day. We try to work for it in a tiny advanced outpost in the hope that it may some day serve as a pattern for a chaotic world.

Our personal problems shrink to insignificance when we are faced with our immediate task: to relieve the misery of others. After a lifetime in hospitals, one finds himself like Tennyson's Ulysses at the end of his wanderings and adventures: "I am a part of all that I have met."

Safe Practices for Surgery

J. WARREN HORTON

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of Technology

THE hazard of possible explosion attending the use of various inhalation anesthetics has long been the subject of intensive study, and diligent search is continuously being made to discover effective safeguards. Not the least of the problems involved in this endeavor is that of making properly accessible to hospitals and to associated interests the conclusions reached and of ensuring their application.

Among the mechanisms available for this purpose the organization of the National Fire Protection Association has unique advantages. Its facilities have, therefore, been drawn upon, and as an outgrowth of its enthusiastic cooperation there have been compiled and published certain safe practice recommendations. There is, however, evidence that, on occasion, the status and, in fact, the purpose and intent of these recommendations have not been clearly understood, with the result that they have failed to attain their primary objective as fully as desired.

It appears necessary, therefore, to clarify the relation of the safe practice recommendations to the hazards of anesthetic explosions and their prevention.

Interprets N.F.P.A. Functions

It is important first to have clearly in mind the interest and responsibility of the N.F.P.A. in this situation. The following is not to be taken as an official statement by that organization but as an interpretation of its function in terms of its potential utility to those concerned with the improvement of conditions in operating rooms.

Viewed thus, the N.F.P.A. is a nonprofit organization, composed largely of public officials, government agencies, professional and trade associations, insurance inspection groups and similar interests concerned with the reduction of loss of life and property by fire. Its responsibility is to ascertain the factors pertinent to the hazards arising in given situations and to define, insofar as possible, the precautions that can be taken.

It must be emphasized that the recommendations of the N.F.P.A. are not in themselves mandatory although they may be incorporated in mandates by other groups having properly constituted authority.

A primary purpose of the organization is, then, to compile the most reliable and complete information available relating to a particularly hazardous situation. This it accomplishes through committees having representation from all interests concerned.

Because of its recognized standing, nonpartisan character and purpose it is able to solicit and to obtain the services of competent advisers who, acting as a coordinated group under its sponsorship, may be expected to conduct a more comprehensive survey than would be possible for any individual or organization having a limited interest. This, in turn, justifies the belief that the published conclusions of such a group represent the latest and most trustworthy opinion available.

For this reason and for this reason alone, compliance with published recommendations of the N.F.P.A. may be accepted as *prima facie* evidence that a conscientious effort has been made to provide every available safeguard.

In any consideration of safeguards care must be exercised to avoid the employment of preventive measures which, although adequately providing protection against a given hazard, may at the same time introduce new hazards or impair essential performance characteristics of the equipment involved. In the case of operating rooms, for example, safeguards against the ignition of explosive vapors must not react to increase the risk of electrical shocks. There is also the inevitable question of distinguishing between frequently occurring situations accompanied by certain risk and situations presenting only a remote possibility of danger.

This second difficulty arose frequently during the preparation of the safe practice recommendations for operating rooms. Wherever doubt existed it was the feeling of the conference committee that its assignment required it to describe safeguards that would ensure protection under all conceivable circumstances, including many which, to date, have fortunately never been found in practice.

The purpose in thus stating the ideal theoretical solution was to provide a secure foundation on which to build rational specifications suitable for general application. This course is in conformity with the usual practice of the N.F.P.A. as evidenced by the fact that for two years adoption of the recommendations was only tentative and that, although now officially approved, they are still subject to further revision.

Publication on this basis is intended to stimulate constructive criticism which is incorporated in final revisions. Had the war not prevented, this course would have been followed in the present case. Now that a return to more normal activity appears possible it is desirable that careful consideration be given to these recommendations and to the consequences of their application in order that the maximum safety can be obtained in operating rooms.

No Explosions From Lamps

An illustration of the general idea mentioned in the preceding paragraphs is furnished by the permanently installed surgical lamp. In all the records of anesthetic explosions there is not one case which can be attributed to the presence of this lamp. In addition to this statistical evidence it is reasonable to assume, on the basis of knowledge regarding the physical properties of anesthetic gases, that it is quite improbable, in fact, almost inconceivable, that an explosive concentration

could exist in proximity to a fixed surgical lamp.

It is known that ether, being considerably heavier than air, has a tendency to seek low levels in a room; it thus moves away from the lamp. Cyclopropane and ethylene are known to disperse rapidly with the result that the inevitable dilution accompanying the escape of mixtures of these gases to the atmosphere promptly renders them harmless. This effect is particularly true of cyclopropane, normal anesthetic mixtures of which are generally already near the lower limit of explosive concentrations.

This last conclusion is, again, supported by statistical evidence, which indicates that anesthetic mixtures containing cyclopropane are rarely, if ever, found to remain explosive for more than a foot or so outside any leak in the anesthetic system.

The region of real hazard may, therefore, reasonably be assumed not to include the fixed surgical lamp. In preparing the safe practice recommendations, however, the committee felt that all possibilities would not be adequately covered if the hazardous location were not defined in such a way as to include the entire operating room unless it was ventilated in accordance with certain stated specifications. In the latter case any position more than 7 feet above the floor was assumed to be nonhazardous.

The ventilating conditions covered by this specification were such as are to be found in virtually every operating room. On the basis of the foregoing, therefore, it appears that the provision of an explosionproof lamp can be justified only if it entails no sacrifice with respect to its primary performance characteristics.

The purpose of a surgical lamp is, obviously, to supply adequate illumination to the surgical area. Adequate illumination may be specified in terms of a number of important factors. First, the intensity of the illumination must exceed some minimum value. Second, the optical arrangement of the illuminating source must be such that this minimum value is exceeded even when one or more of the operating staff are between the source and the surgical area and when deep incisions are involved.

To aid the surgeon in the proper identification of tissues and their condition it is imperative that the light supplied have certain specifiable color characteristics. In addition to all this, the lamp must be easily movable so that its illumination can be properly directed, regardless of the position of the patient and the staff or the location of the incision. Finally, the heat generated by the lamp must not be allowed to cause discomfort or injury to patient or staff.

Should any attempt to provide an explosionproof fixture result in a sacrifice in any of these performance characteristics, the end result may prove to be a reduction in the security of the patient considered as a whole.

Considerations of performance are by no means the only factors to be taken into account. It is undeniably true that the expense to a hospital of procuring and installing an explosionproof lamp is considerably greater than the cost of commercial units now available. It would appear that any significant increase in expenditure is not justified in the light of existing information.

Objection has frequently been raised that the safe practice recommendations for operating rooms may result in the enforcement of regulations that will be difficult for hospitals to meet. Actually the situation at the moment is that local authorities frequently base their criterion of acceptability on the more general National Electrical Code which, unfortunately, does not as yet recognize the operating room as a unique type of hazardous location and the requirements imposed by this code are the same as for industrial locations.

To meet these requirements, operating room fixed lights must not introduce any hazard when in an atmosphere capable of anesthetizing the entire surgical staff! It is, therefore, believed that the N.F.P.A. safe practice recommendations for operating rooms, when generally accepted, will effect a simplification of the hospitals' problems in this matter rather than increase them, as feared.

Question of the Month

QUESTION: I am interested in knowing the percentage of cash *vs.* investments that voluntary hospitals should maintain, particularly today when government bonds are considered almost as good as cash. Also, the type of investment portfolios especially exclusive of any fixed endowments which may not be converted into cash for current or capital expenditures.—W.J.A.

ANSWER: Most financial committees, it is believed, follow the practice of keeping cash invested at all times. In some hospitals a certain proportion of the endowment fund is nonrestricted and the principal may be used as the board may decide for current or capital expenditures. Whereas this is not recommended it would not necessarily make any great difference in the portfolio investments. Perhaps a higher percentage would go into relatively stable securities, such as government obligations or short maturity bonds. But the diversion of funds to current or capital requirements from the endowment portfolio would probably never require liquidation of more than a reasonable part of the assets at any one time.

One hospital with an endowment of $856,196.34 distributes its investments as follows: governments, $165,140; other high grade bonds, $77,690; real estate mortgages, $210,572.58; preferred stocks, $163,805; common stocks, $223,360, and guaranteed mortgage certificates, $15,627.76.

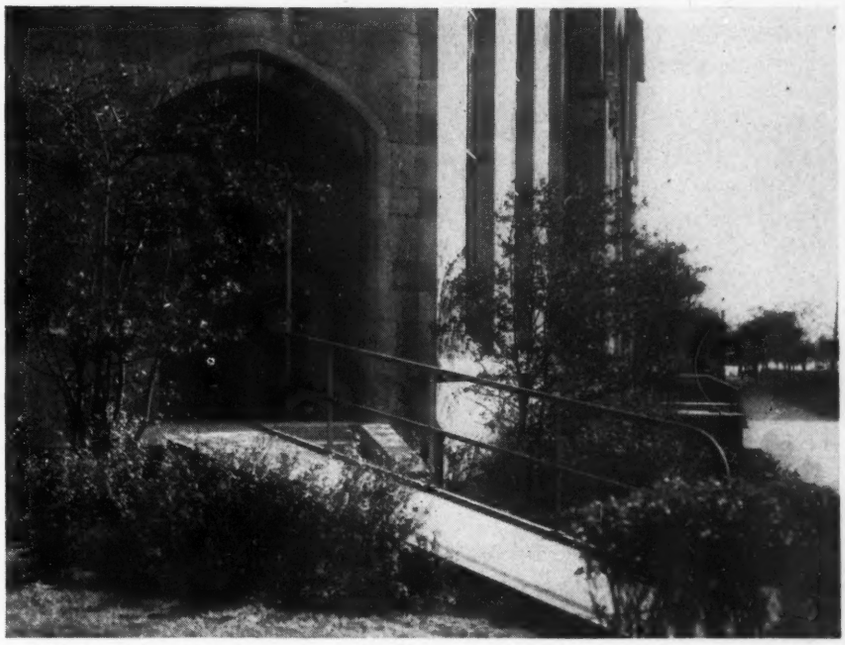
In other words, the percentage of total bonds, including mortgages, is 55 per cent; of bonds and preferred stocks, 75 per cent; of common stocks, 26 per cent. The yield is 3.75 per cent.

Of the preferred stocks in this particular portfolio, 54 per cent are in utilities and railroads, and 46 per cent, in industrial stock. Of the common stock, 32 per cent is in banks and utilities with 68 per cent in industrial stocks. Bonds are divided as follows: 21 per cent, utilities and railroads; 6 per cent, commercial; 61 per cent, U. S. government bonds, and 12 per cent, other government bonds.

This fund is watched constantly by two members of the board both of whom are in daily touch with the market. They have been particularly successful and with the exception of some real estate mortgages which were not of their own selection no losses have been incurred. Through their efforts all real estate mortgages have now been placed on an amortization basis and a few unsatisfactory mortgages have been foreclosed or sold to other investors.

The Barrier of Steps

MARGARET POPE HOVEY
Chairman, Architect's Advisory Committee
National Society for
Crippled Children and Adults
Chicago



Wesley Memorial Hospital, Chicago, provides a ramp at one entrance.

HAVE you ever faced a flight of icy steps and realized with what care you must place each foot as you toil upward? Or have you tried to enter almost any public building and counted with dismay the steps to the front door? If so, you would gladly do away with the classic beauty of imposing flights of stairs which terrace our public buildings and become discouraging barriers for a large group of citizens.

This group is growing rapidly with the return of handicapped veterans to civilian life and with the increase of crippling accidents through transportation or industry. And there are always those crippled by disease or accident at birth.

Hospitals, more aware than others of the health needs in any community, can take the lead in building plans and remodeling to do away with flights of steps to reach the entrance or the inner stairs from the front door to first floor level.

Boards working with their architects can do away with the frustration and fatigue which even a moderate flight of stairs means to the handicapped and can design the front entrance on the grade level. No longer must the basement be placed partially above ground, since forced ventilation and artificial lighting now make this unnecessary, and the first floor level can be evenly graded to the street.

City hospitals, built flush to the building line of the sidewalk like department stores and movie houses, may afford street level entrances, but how many of them avoid stairs within, leading to the first floor level? Stores and movies, impelled by the profit motive, make it easy for all individuals to use their facilities. Should not all buildings used by the public be as readily accessible?

One story hospitals in smaller communities, despite the natural setting of spacious grounds, may have an innocuous approach flight of six to eight low steps without realizing the difficulty this presents to the crippled patients or those handicapped with heart ailments. Take them away and let a driveway sweep up to a grade level entrance and you provide comfort, convenience and care to hundreds of persons using the building within the year.

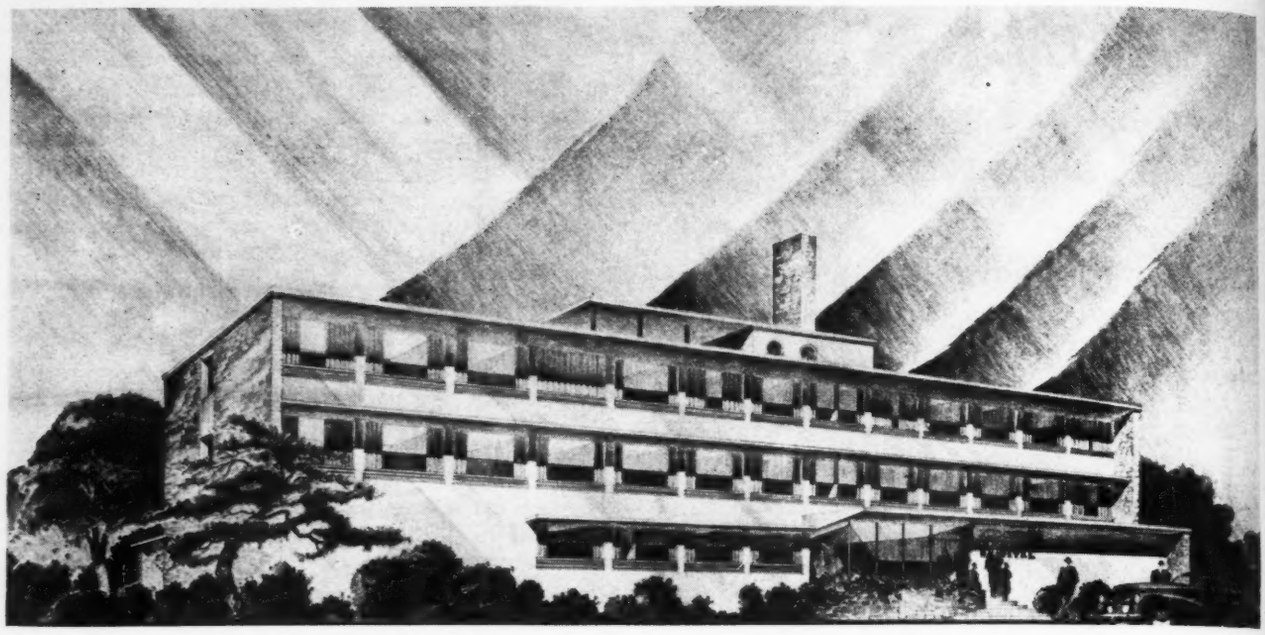
During the pause in building operations, forced by war necessities, the National Society for Crippled Children and Adults has been bringing to the attention of architects and boards of all public buildings the needs of the crippled and handicapped for grade level entrances. As chairman, they selected a member of the Illinois Commission for Handicapped Children who made the initial study of this problem, agreed to have national scope.

The society appointed an architect's advisory committee of which the late Col. John Holabird of Holabird and Root was a member, together with C. Herrick Hammond, state architect of Illinois, and M. Edwin Green of Lawrie and Green, Harrisburg, Pa., to advise lay members from the staffs of the national society and the Illinois Association for the Crippled.

The committee believes that the use and enjoyment of all public buildings can be made possible for the handicapped as well as the non-handicapped if planning boards, architects and public officials can unite in building under the following program:

1. Eliminate outside steps to public buildings. Where flights of steps exist, provide a grade level entrance.
2. Whenever possible, place elevators adjacent to the ground floor entrance.
3. Eliminate steps inside buildings. If this is impossible, provide ramps.
4. Whenever steps cannot be eliminated, place hand rails on both sides of steps, the full length of flights.
5. In designing public buildings, include plans for an enclosed driveway adjacent to a garage or parking space.
6. Eliminate heavy doors. Where there are revolving outside doors, provide auxiliary swinging doors of light construction.
7. Eliminate high curbs at street crossings through the use of culverts.
8. Lower steps on buses, streetcars and all public conveyances.

The committee is confident that hospital managements, planning boards and other civic groups, when aware of existing building obstructions, will accept community responsibility for making present and future buildings available to all citizens through practical remodeling of existing facilities and thoughtful planning of new buildings.



Better Care for Negroes

LAWRENCE PERKINS
Perkins, Wheeler and Will
Architects, Chicago

THIS 54 bed general hospital has been planned to replace a 25 bed obsolete institution now serving the 6700 Negroes on the west side of Evanston, Ill., and the 5000 or more in the northern part of Chicago. The hospital has an all-Negro medical, nursing and administrative staff but an interracial board of trustees headed by Clyde Foster, president.

As may be seen from the elevation and plans, the hospital faces south and is definitely a "solar hospital," full use being made of the winter sun for heat and cheer. Overhangs cut off most of the summer sun except in morning and afternoon.

Although the plans are ambitious for a small group, an attempt is to be made to give the Negroes of Evanston the kind of hospital they really need.

CONSTRUCTION: Fireproof throughout. Exterior, Lannon limestone and concrete. Interior partitions, 2 inch plaster on sheetrock. Fixed double-glazed windows with ventilating function separated from lighting function. Stairways, precast concrete with terrazzo finish.

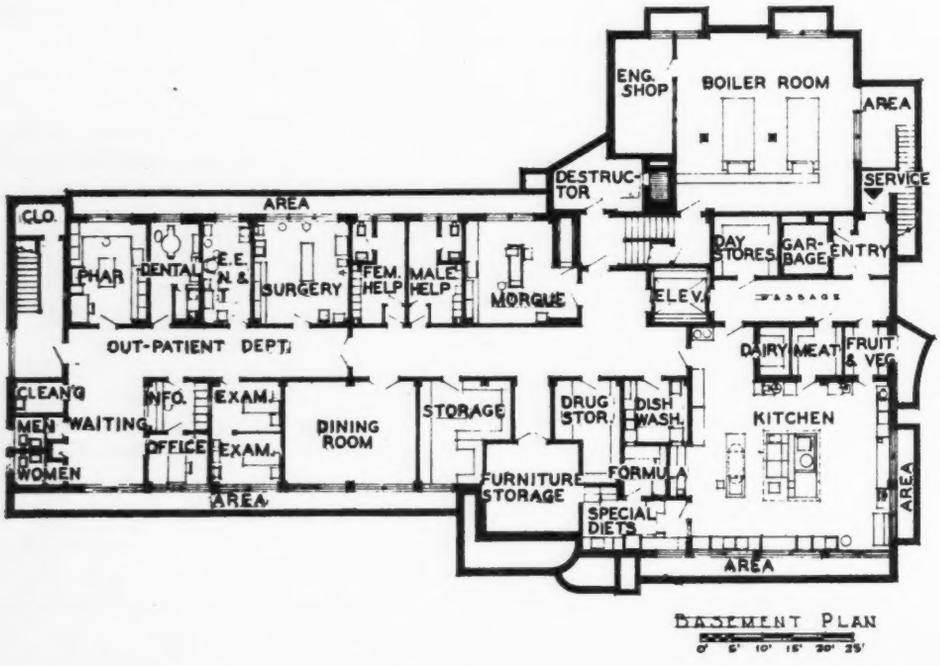
HEATING: Oil-fired radiant heating with forced hot water in floors and ceilings throughout.

VENTILATION AND AIR CONDITIONING: Ventilation through louvers with fixed screens so that the room is always protected from storms and insects. Unit air conditioning in operating rooms and clinical departments.

REFRIGERATION: Unit systems throughout.

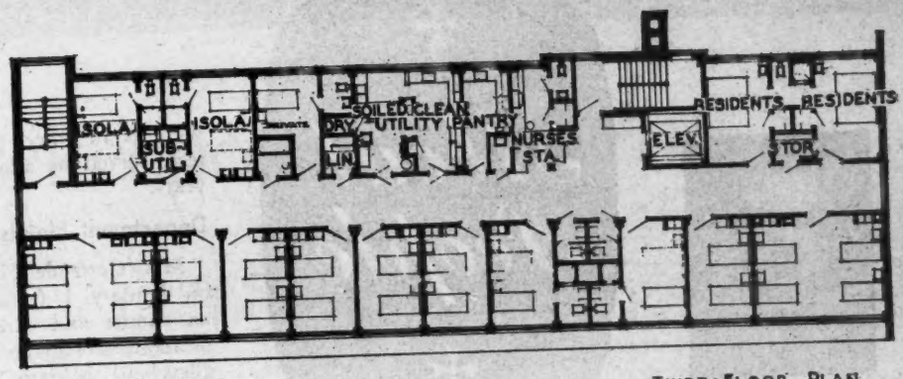
KITCHEN: Glazed tile floors and walls, stainless steel fixtures, electric ranges.

COSTS: Estimated total cost of building and equipment, excluding land, $250,000. Cost per bed, $4555. Funds are now being raised from the Negro community for the construction of the hospital.

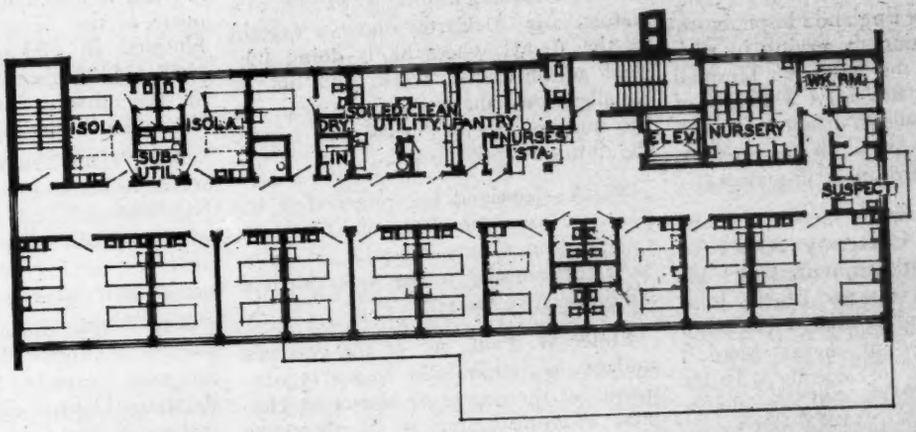


BASEMENT PLAN

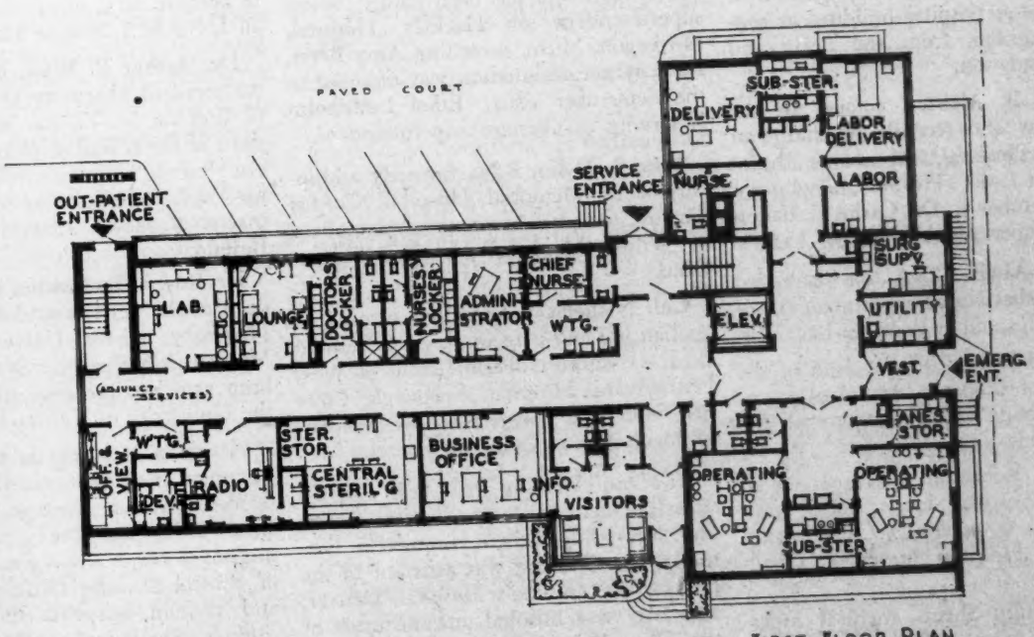
The plans on this and the opposite page show the proposed layout of the four story building to be erected in Evanston, Ill., to serve the Negro population. The basement and first floor will house service areas, operating and examining rooms and administrative offices, while the two upper floors will be devoted to patients' rooms.



THIRD FLOOR PLAN



SECOND FLOOR PLAN



FIRST FLOOR PLAN

About People

Administrators

Oliver G. Pratt, director of Salem Hospital, Salem, Mass., since 1931, has submitted his resignation in order to assume the duties of director of Rhode Island Hospital at Providence on January 1. Mr. Pratt, a member of The MODERN HOSPITAL editorial board, is active in both regional and national hospital affairs. He has held numerous offices in the Massachusetts and New England Hospital associations, in addition to serving in various capacities in the American Hospital Association. He has been a fellow of the American College of Hospital Administrators since 1939. He succeeds **Dr. Dennett L. Richardson** at Providence.

Dr. Beryl I. Burns, former dean of the Louisiana State University School of Medicine, New Orleans, will assume his duties as medical director of the John Sealy Hospital and Affiliated Hospitals of the University of Texas Medical Branch, Galveston, in December. In his new post, Doctor Burns will have charge of professional activities and will be assisted by **William O. Bohman,** superintendent of the John Sealy Hospital, in respect to administrative details. He will act also as consultant in the erection of a new general hospital building as provided by grants from the Sealy and Smith Foundation.

William B. Meister, colonel in the U. S. Army and recently in charge of West Point Hospital, will become administrator of St. Luke's Hospital, Newburgh, N. Y., December 1. **Dr. Carlos E. Fallon** is acting superintendent at St. Luke's.

Sister M. Alwin, C.S.A., has succeeded **Sister M. Sebastian** as superintendent of St. Agnes Hospital at Fond du Lac, Wis.

Dr. Ward Darley is now dean of the University of Colorado School of Medicine and acting superintendent of the University Hospital, Denver.

Helen M. Robinson, administrator of University Hospital, Little Rock, Ark., has resigned to accept the directorship of the State Hospital Survey on a full-time basis.

Dr. R. Philip Sheets, medical superintendent of Traverse City State Hospital, Traverse City, Mich., will be in charge of the state mental disease hospital, and **Bennett McCarthy** will administer the acute general hospital as the result of the separation of the Neuro-Psychiatric and the General Hospital by passage of a statute. Mr. McCarthy, now a captain in the Army, where he is doing hospital administrative work, will not be installed until the first of the year. In the interim, Doctor Sheets will handle the duties of both posts.

W. A. Copeland has returned to his post as superintendent of Wyoming County Community Hospital, Warsaw, N. Y., after service in the Army Medical Administrative Corps.

Elmer W. Paul, one of the two first students to complete the course requirements for the degree of Master in Hospital Administration at Northwestern University, is at present serving his administrative internship at Wesley Memorial Hospital in Chicago.

Bob D. Dann has been named acting superintendent of Hackley Hospital, Muskegon, Mich., suceeding **Amy Beers, R.N.,** whose resignation was reported in the September issue. **Ethel Lundholm** is serving as assistant superintendent.

Elsie L. Delin, R.N., formerly administrator of Memorial Hospital, Corpus Christi, Tex., has become superintendent of Wilson Memorial Hospital, Sidney, Ohio.

Col. Nicholas J. Sepp is returning to civilian life and is reentering the hospital field as assistant superintendent of West Pennsylvania Hospital, Pittsburgh. Colonel Sepp was formerly superintendent of Shadyside Hospital in that city.

Rowland Dearing has been named superintendent of Corry Hospital, Corry, Pa., succeeding **Edwin Saunders.** Formerly, Mr. Dearing was assistant to the director of Children's Hospital, Denver, and later was hospital administrator of the War Relocation Authority, Heart Mountain, Wyo.

W. H. Markey Jr., assistant administrator of Shadyside Hospital, Pittsburgh, has been named head of the hospital. Mr. Markey succeeds **J. S. Hammond** who, as an officer of the board of trustees, served as administrator for three years.

Department Heads

Mrs. Gertrude Fife, R.N., will retire on January 1 from her post as chief anesthetist and director of the school of anesthesiology at University Hospitals, Cleveland, **Miriam Shupp,** of the anesthesia department of Strong Memorial Hospital, Rochester, N. Y., will succeed Mrs. Fife.

Maj. Floramund Fellmeth Difford, A.N.C., has been named principal chief nurse at the Army's Gardiner General Hospital in Chicago succeeding **Maj. Nellie M. Denison.** Major Difford was the last nurse to leave Manila before it was taken by the Japanese.

Mrs. Viola Trumble has resigned as executive housekeeper at Grace Hospital, New Haven, Conn. **Mrs. Laura Wright,** who has been associated with the hospital for the last four years, has been named her successor.

Kay Walsh, director of volunteers at Wesley Memorial Hospital, Chicago, is resigning December 1 to join the Public Relations Department of Textron, Inc., makers of fabrics.

Joe Hogan has resigned as chief engineer and administrative assistant at Buffalo General Hospital, Buffalo, N. Y., to become chief supervising engineer for all U.S.P.H.S. Marine Hospitals.

Dr. Arthur P. Wyss, head of the department of pharmacy at the University of Buffalo, N. Y., has been selected as dean of the school of pharmacy at Western Reserve University, Cleveland. Doctor Wyss served also as consulting pharmacist at Meyer Memorial Hospital at Buffalo.

Dr. Roy A. Bowers has been appointed dean of the newly established College of Pharmacy at the University of New Mexico, Albuquerque, N. M. He has been associate professor of pharmacy at the University of Kansas at Lawrence.

Henrietta McNary, director of the department of occupational therapy at Milwaukee-Downer College, Milwaukee, since 1939, has been granted a six months' leave of absence to make a study of clinical training facilities in military and civilian hospitals throughout the country. She is making the study for the American Occupational Therapy Association.

Katherine Averill is now executive housekeeper at Kapiolani Hospital, Honolulu, T. H. Mrs. Averill is a member of

(*Continued on Page* 178)

Housekeepers to the Fore

HOUSEKEEPING is coming up in the world—the small hospital world, at any rate. Early in 1944, the problems of housekeeping were the subject of a Small Hospital Forum and of nine hospitals that replied to the questionnaire, only one reported having a full-time housekeeper. In view of the importance of housekeeping, it was decided to take up the subject again and this time six of 11 hospitals that returned questionnaires (50 were sent out) report having a housekeeper.

Of the five institutions that report that housekeeping duties are handled by someone other than a housekeeper, only two state that the administrator officiates in this capacity. In two, the supervisor of nurses is responsible and in one, a graduate nurse, who is also in charge of supplies, has a "miscellaneous" job that includes housekeeping.

Most Prefer a Housekeeper

All 11 respondents are apparently agreed that, ideally, the administrator should not add housekeeping to her numerous burdens. Three did not answer the question as to what constitutes the best arrangement for the small hospital, but of the eight who did, five vote for a housekeeper, two prefer to combine housekeeping duties with some other type of work and one recommends having the supervisor of nurses actually in charge of the department with a housekeeper under her "so that there is no conflicting authority."

The second question on the agenda dealt with interior decorating and on this point it seems that, with only one exception, everyone *but* the housekeeper has something to say. Responsibility for deciding on color schemes and selection of furniture rests solely on the administrator in four instances. In six of the remaining seven hospitals the administrator consults with other members of the organization, as follows: superintendent of nurses (one hospital); nursing staff and trustees (one); housekeeper and secretary (one); maintenance man, director of nurses and department heads (one); painter (one), and chairman of the finance committee (one).

At Ellsworth Hospital, Ellsworth, Kan., Supt. Tressa Pierson reports, the local painter advises on the color scheme. "We always use subdued tones and try to use tints of yellow and rose in the north rooms and green and, occasionally, blue in the south rooms," she writes.

How many times a year do you wash walls? How often do you paint rooms? How often do you wash windows? Perhaps these were not fair questions inasmuch as the manpower situation has not improved appreciably as yet. However, several hospitals were able to report that they keep to definite schedules as follows.

"When We Have Help"

Walls are washed once a year in two institutions; every four months in one; every two months in one; once a month in one, and "as needed" or "when we have help" in the remainder.

Rooms and corridors are painted every year (one hospital); every two or three years (two); every three or four years (two), and "as needed" (six).

Window washing schedules range from semiweekly to once a year, with almost as many variations as there are answers. On the whole, the answers indicate that these maintenance activities have been kept up

CLEANING INSTRUCTIONS
Ellsworth Hospital
Ellsworth, Kan.

Occupied Rooms

Remove all flowers and plants to utility room.

Dust floor and mop with wet mop once each week or at once when something has been spilled on the floor.

Dust furniture and window sills, starting on far side of room from door.

Remove all used papers, all books and magazines that patients are through with and put away any personal articles that the patient will not be using for several hours at least.

Clean bed frame with damp clean cloth if metal or with dry cloth if wood.

Clean lavatory, glass dresser tops and table tops and mirror with proper cleaner.

Clean emesis pan and replace on table.

Rearrange flowers, place in fresh water in clean vase and take to patient's room.

After Discharge of Patient

Remove all linen, including curtains, from room.

Remove all articles from bedside tables, dresser drawers and closets.

Sweep floor, then mop with hot soapy water.

Clean inside window panes.

Wash rubber sheet.

Wash all metal furniture.

Clean lavatory and clean and polish all glass tops and mirrors.

Wash bed and, if wood, polish with furniture polish.

Clean dressers inside and out.

Polish all woodwork.

Hang clean curtains.

Clean and replace regular utensils.

Place furniture in order, make bed and apply clean table covers.

surprisingly well in view of the trying conditions.

In most small hospitals, judging from the replies to this questionnaire and the one sent out in 1944, it is not customary to prepare written instruction sheets for maids and porters on the proper procedures to be followed in cleaning rooms, both while they are occupied by the patients and after the patients' discharge. In most cases instructions are given verbally by the housekeeper, when there is one, or by the person in charge of the department.

At Ellsworth Hospital, Miss Pierson states, "We do not need instructions for our regular maids and floor man but do put out printed instructions during vacation periods when we have untrained workers." (See panel on page 91.)

Other replies on this question are as follows:

"We have no typed instructions yet. The oldest maid has been with us twelve years. She is an excellent housekeeper and sets a standard for the others."—AUGUSTA CHRISTIANSON, *Mary Lanning Memorial Hospital, Hastings, Neb.*

"While the patient is in the room, maids keep the room dry-mopped and dusted. After discharge of patient, the room is completely cleaned."—GEORGE W. HILTON, *Rockingham County Home and Hospital, Epping, N. H.*

"Avoid cleaning in patients' rooms during treatments and visiting hours. Do dusting of room after bed is made and morning care is given."—JAMES L. DACK, *Community Hospital, Battle Creek, Mich.*

"Maids are instructed by department heads. We have no typed instructions but think they would be helpful. However, labor turnover is so great that even typed directions would be of little value."—SISTER STANISLAUS, R.N., *St. Mary's Hospital, Astoria, Ore.*

"Depends on type of case in room at time of discharge."—C. O. WOLFF, M.D., *Haynesville Hospital, Haynesville, La.*

"The housekeeper trains her maids. She has them clean bedsprings, dust mattresses, wipe down walls and all drawers and closets."—GLADYS PHIPPS, *National Homeopathic Hospital, Washington, D. C.*

"No specific instructions given."—MARY J. TAYLOR, R.N., *Samaritan Hospital, Ashland, Ohio.*

"Thorough cleaning of rooms, according to well-established technics."—A. G. TVERBERG, *Grafton Deaconess Hospital, Grafton, N. D.*

Asked what changes in methods, frequency or thoroughness of room cleaning they had made during the war, seven hospitals replied that they had made little or none and three answered that they had not been able to do as much or as thorough cleaning because of lack of help and also because the demand for rooms was such that there wasn't time to clean thoroughly.

Apparently there are few short cuts to cleanliness since only two hospitals report that they have found satisfactory methods of speeding up cleaning operations. Miss Christianson of Mary Lanning Memorial Hospital states: "We have tried to put as much equipment on wheels as possible and have given our folk more modern maintenance equipment than they ever had before."

Miss Pierson's method is: "By asking head nurses and supervisors to teach all nurses working under them to practice good housekeeping methods, to clean properly and put in its place all equipment used by them, to report shortages or defective equipment and supplies and to conserve on linen at all times, using each article for one purpose only."

She feels, as does Miss Christianson, that the hospital will derive some benefit from these practices developed as a result of war-time exigencies because "we have had to go without many articles and have still been able to give just as good care to many more people with a much smaller staff of workers. Especially in regard to linen and paper goods, we should realize how extravagant we have been."

Optimistically, the questionnaire wound up with the following query: "Have you obtained any volunteers to help in housekeeping?"

The answer, repeated 11 times, was "No."

VOLUNTEER ACTIVITIES

Lobby Decoration

At Allerton Hospital, Brookline, Mass., the volunteers are called Pink Ladies. In the hospital lobby hangs a Pink Lady Honor Roll containing the names of all volunteers who have served more than 500 hours.

Gray Lady Extraordinary

Not all Gray Ladies have needed a hospital orientation course before starting their duties. Take that unusual Gray Lady, Helen V. Gardner, who has made 10,000 towels for the naval hospital at Oak Knoll, Calif.; she has hung up a record for achievements other than towels.

The reason Miss Gardner needed no orientation course is that she had one back in Spanish-American war days—not as a volunteer and amateur, however, for she completed her nurses' training at Garfield Hospital, Washington, D. C., in 1898. Miss Gardner became a Red Cross nurse in 1912 and holds enrollment badge No. 30; she is still a member of the Red Cross Nurse Reserve.

During World War I, Miss Gardner acted as home nursing examiner for the District of Columbia; after the war she moved to California to do private nursing and World War II brought her back within hospital walls again as a Gray Lady extraordinary.

Nantucket's Thrift Shop

On Nantucket Island, Nantucket, Mass., the ladies who comprise the auxiliary of Nantucket Cottage Hospital have to "make hay" while the summer sun shines. During the summer months the island's population jumps to nearly 22,000-from a normal 3200. So each year they get started early to make plans for the Thrift Shop, which they have been operating successfully for many years for the benefit of the hospital. It is in reality a glorified rummage sale which starts early in June and lasts all summer. One full-time manager is paid; the rest are members of the auxiliary.

Early in the season, usually in May, the ladies start the ball rolling by holding a "bundle tea" at the home of some member. Price of admission is a bundle for the shop. Right then and there enough merchandise is provided to start operations. And if anyone questions the financial success of the undertaking, he has only to stop in at the hospital and take a look at the x-ray equipment, modern lighting and the new operating room that have been provided from this source.

After the last summer visitor has gone, the island settles down to its winter routine and the hospital ladies get busy with needle and thread to do sewing and make dressings.

HEADLINE NEWS

These Names Were News at the Chicago Meeting of the A.H.A. Delegates

Don Smelzer bowed out of the presidency with a neat story about **Peter Ward,** who bowed in with a sober, fact-facing address. . . . **John Hayes** was named president-elect by all delegates and poet laureate of the association by many, but there were some who backed **Stanley Howe** as champion versifier when he popped up on the floor with a dozen original stanzas about the new president. . . . The verses that **Bob Jolly** recited to underscore his opinion of **John Mannix** as a man who gets things done were strictly from Edgar Guest. . . . **Msgr. Maurice Griffin,** trustee since the memory of man runneth not to the contrary, retired from officialdom with this meeting and was replaced on the board by **Rev. John Barrett** of Chicago. . . . **Ritz Heerman** sparked the discussion of social security by warning delegates that asking for removal of exemptions might prove to be the wedge's thin edge. . . . **Joe Norby** reported that his committee had counted noses at headquarters and found too many to fit, so it's good-bye to the old Division Street homestead as soon as *lebensraum* can be found for, among others, **Maurice Norby** and his Commission on Hospital Care staff, whose monumental survey was the subject of a lucid report by director **Arthur Bachmeyer** after a brilliant introduction during which **Graham Davis** touched hospitals in a few tender spots. . . . **George Bugbee** took on all comers in a free-style question period on S. 191 and had the answers at his fingertips. . . . **Bob Buerki** led the delegates through the mathematical maze of a proposed plan to reconvert from 9-9-9, leaving them groggy but game for anything that will help speed return of men in uniform. . . . **Jim Hamilton** retired from official association life by asking to be relieved as chairman of the Council on Education, thus leaving the championship in extemporaneous eloquence wide open. . . . After reporting up-to-the-minute totals on the cadet nurse corps, **Lucile Petry** looked into the future of nursing and saw better schools turning out two kinds of nurses, professional and practical. . . . Biggest newspaper headlines went to **Reg Cahalane,** who made page one when he urged hospitals and Blue Cross to tell their story in paid advertising. . . . Working hard and late to keep the meeting in the papers was **Jon Jonkel,** but the hardest worker of all, bar none, was **Ruth Wilkie,** who sat at the head table from open to close catching pearls of wisdom, by the thousand, on her stenotype.

Harmony Prevails at A.H.A. Sessions John Hayes Is President-Elect

John H. Hayes, superintendent of Lenox Hill Hospital, New York City, is the president-elect of the American Hospital Association.

Veterans' care, hospital legislation, security for hospital employes and the extension of hospital service by aggressive Blue Cross promotion and other means were the chief topics for discussion and action at the smooth-running meeting of the A.H.A. House of Delegates in Chicago November 5, 6 and 7. Including officers, delegates, members present to read special reports and guests, attendance at most of the sessions numbered around 100.

With only one notable exception, the house approved the reports presented by officers and took action as recommended through regular channels. While several of the reports met with lively discussion, no strongly opposing views developed on any issue; as a result, every session closed within a few minutes of scheduled time, with the agenda completed.

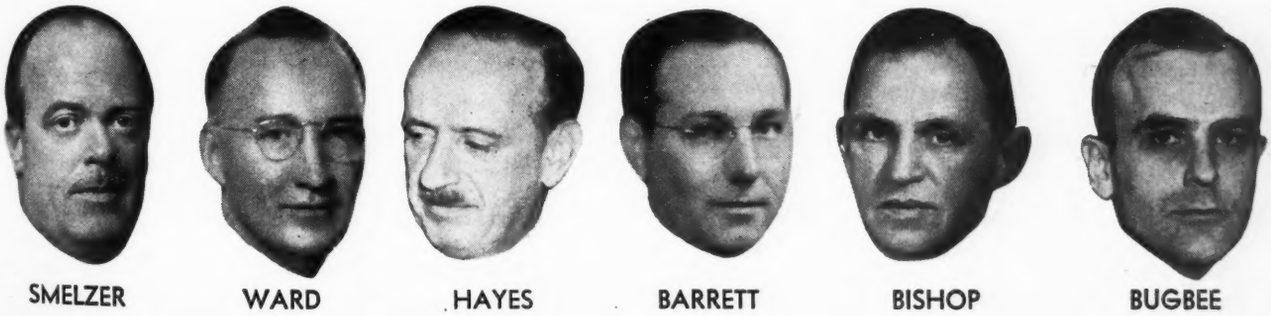
Expressions of satisfaction with the way the association has functioned during the last year were frequent and manifestly sincere. In contrast to the perfunctory "we acknowledge with thanks" which is the characteristic conclusion of committee reports the world over, council and commission chairmen and, on a number of occasions, delegates speaking from the floor paid earnest tribute to the leadership of executive director George Bugbee and his headquarters staff, often specifying the exact nature—with names, dates and places—of the assistance furnished.

Only break in the otherwise uninterrupted harmony of the meeting occurred when delegates balked at setting up minimum enrollment requirements as requisites for continued approval of Blue Cross plans. This action was urged on the house as a means of strengthening the plan program by John Mannix, Blue Cross Commission chairman, and Lewis

(*Continued on Page* 136)

A.H.A. Plans New Home

The A.H.A. headquarters building in Chicago is inadequate for present needs, and immediate steps will be taken to purchase a new building or to lease suitable facilities while plans are made for construction of a new headquarters building. This action was taken by the House of Delegates following presentation of the report of a special committee on housing of headquarters. The committee studied the present building in relation to existing and anticipated staff needs and concluded that no rebuilding or modernization program was sensible, Joseph G. Norby, chairman, reported. The Board of Trustees was of the opinion that funds for the provision of adequate headquarters space would be available, he said.



SMELZER WARD HAYES BARRETT BISHOP BUGBEE

A.H.A. Takes First Step Toward Providing Retirement Benefits for Employes

The first step toward assuring retirement benefits for hospital employes all over the country was taken by A.H.A. delegates meeting in Chicago November 5. In their opening session, the delegates approved a plan to form a corporation which will operate a pension trust that all hospitals will be eligible to join.

Prior to discussion and action on the pension plan, the House of Delegates formally approved removal of the exemption of nonprofit hospitals from the federal social security laws providing old age benefits and recommended that the Council on Government Relations actively promote the inclusion of hospital employes under federal old age benefits. It was specifically stipulated, however, that no such action be taken in connection with the unemployment insurance features of social security.

Action on the social security recommendation was taken over the protests of several delegates who felt that it would be a mistake to disturb the present tax-exempt status of hospitals in any way.

The program to set up a pension trust for hospital employes was presented in detail by Peter Husch, St. Louis attorney, a member of the special study committee established to investigate the subject and make recommendations to the association. A poll of 1165 hospitals revealed that only 43 nonprofit institutions in the group already provided retirement benefits for employes, while over 1000 felt that some such program was desirable and said they would join if the committee made a pension plan available to them.

Briefly, it is contemplated that eligible employes will contribute 3 per cent of their pay and hospitals, 5 per cent of the pay roll for participating employes, to set up a retirement benefit for employes reaching age 65. The amount of the benefit, of course, will depend on the amount contributed in each case as determined by the individual employe's length of service and rate of pay. Additional contributions will make it possible for hospitals wishing to do so to add consideration of service already accrued at the time the plan is installed, though in no case will such past service rendered before age 35 be allowed to earn any benefit.

Underwritten by one of the large life insurance companies, the plan is similar to pension trusts which have been established in most large industries during the past few years. No death benefit is included, as the committee that

(*Continued on Page* 130)

Complete Plan for Qualifying Architects

The A.H.A. program for qualifying hospital architects has been fully formulated and applications for qualification are being received in increasing numbers, Frank R. Bradley, chairman of the council on hospital planning and plant operation, reported.

This program was undertaken in support of the belief that an architect responsible for the design of a hospital must have an intimate knowledge of how the building is to function, Bradley said. A committee of hospital administrators and architects drew up details of the qualifying procedure.

Hospital building committees should be encouraged to employ architects listed in the association roster or to require unlisted architects to associate themselves with qualified hospital experts during the course of a hospital building project, Bradley stated. "The council believes that adherence to this practice will, by providing more efficient hospital care, contribute substantially to the welfare of this country," he concluded.

More Time Needed to Complete Surveys

It is plain today that the work of the Commission on Hospital Care cannot be completed within the two year scope of its original authorization, Dr. Arthur C. Bachmeyer, director of the commission, reported at the A.H.A. delegates' meeting. Doctor Bachmeyer reviewed the procedures that were used to stimulate the formation and action of survey groups in the various states.

Not one state remains, he said, in which the survey of hospital and related services is not already under way or definitely planned for. Nevertheless, he added, the pilot study conducted in Michigan demonstrates that the survey is a time-consuming project and that the proper evaluation and interpretation of survey findings are in themselves major undertakings.

Preliminary findings by the commission already point the way toward many possibilities for effecting economies and improving hospital care through the integration of various kinds of institutions and services, Doctor Bachmeyer stated.

Urge Greater Use of Community Hospitals for Care of Veterans

Government should finance hospital and medical care of veterans for service-connected disabilities, and for nonservice-connected disabilities in the case of veterans unable to pay for their own care, but these services should be rendered as far as possible by expansion of community hospital facilities rather than by construction of general hospitals for veterans only.

These were the principles approved by the A.H.A. House of Delegates on recommendations made by a special committee on veterans' care headed by Arden E. Hardgrove of Norton Memorial Infirmary, Louisville, Ky. Added recommendations of the committee, which was appointed by the council on government relations, were also approved by the House and included:

1. Veterans should have free choice of hospital and doctor for all short-term and acute illnesses.
2. Out-patient facilities in both veterans' and community hospitals should be freely available.
3. Voluntary hospitals should be reimbursed for veterans' care under simplified contracts assuring payment of equitable costs.
4. Medical and hospital care should be provided under separate contracts.

Speaking informally at a dinner meeting of delegates and guests, Lt. Col. Harry E. Brown, acting director of hospital service for the Veterans Administration, stated that increasing use of community hospitals for veterans—up to a possible ceiling of 20,000 beds—was inevitable because the number of veterans needing care will be too large to make handling in veterans' hospitals alone feasible. There are approximately 6500 veterans being cared for in voluntary hospitals now, Colonel Brown said, under contracts calling for payments between $5 and $8 a day. Answering a question about the provision of medical care, Colonel Brown said it was hoped that eventually all physicians would accept contracts to care for veterans.

Ask Help of A.H.A.

The State Department has asked the A.H.A. to furnish its technical information and skill to health authorities in Central Europe as an aid to rebuilding facilities and organizations demolished by war, Dr. Malcolm T. MacEachern, chairman of the council on international relations, reported to the House of Delegates.

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DISCUSSIONS of how to provide all the people with adequate medical care usually end with the participants divided into three main camps, an assortment of outposts on the periphery of each and an inevitable few scurrying from one to the other. These three main camps may be described generally as believing that:

1. Things are all right as they are, with a few regrettable exceptions.
2. The organization and administration of health services should be at a local level, with state government performing a coordinating function and federal government participation, if any, limited to grants-in-aid to states.
3. National direction and financing of health services are needed now.

Something Must Be Done

Any objective review of the facts seems to support the premise that America's clinical and administrative skills and her financial resources have not yet been combined most effectively in the interest of the patient. Most sincere discussants agree that something must be done. The disagreement centers about what that something should be.

Supporters of each group can marshal a whole series of arguments against the other two. Discussion can never be constructive when limited to criticism of opposing positions. Yet, it is difficult to support factually the positive reasons for choosing any one of these positions. The choice is a matter of opinion and judgment, a weighing of a mass of evidence the evaluation of which must be affected by the prejudices of the assayer.

One of the criticisms of the second position heard most frequently from the partisans of the "federal program now" group is that the needs are so urgent as to demand immediate federal action. Through no other means, they say, can enough progress be made promptly. The needs are urgent, hence any sincere supporter of the second position must satisfy himself that progress will evolve under that program as rapidly as is consistent with sound development —progress which will, in fact, be toward the final objective of healthier, happier, more useful citizens.

The needs of sick people are so personal and appealing that often one is tempted to seek a sweeping final solution. The rate of progress one may expect under a nonfederal program is, therefore, a basic consideration.

Let us examine recent events in Maryland to determine how much progress we can expect without the lash of federal funds. Frequently, the medical profession is charged with obstructionist tactics. No one can justly accuse the medical profession in Maryland of being satisfied with the status quo. Of its own volition, without artificial stimulus, it has taken constructive action in several directions.

Maryland's Blue Cross plan is perhaps the first to stem directly from action of a state medical society.

In 1941 the state medical society forced through, against considerable opposition, a bill replacing coroners with medical examiners.

In 1939 the medical society drafted a statesman-like letter which began with these paragraphs:

"The Medical and Chirurgical Faculty of Maryland desires to draw your attention to the advantages of constituting a new section or standing committee of the State Planning Commission whose function it shall be to keep under constant survey the problems of medical care for the citizens of this state and to formulate from time to time recommendations for better utilization and for extension of existing medical facilities and for the institution of such new facilities as are required.

"We are using the term 'medical care' in an inclusive sense to cover all the agencies available in safeguarding and improving the health of the people and in the treatment of disease. It may be interpreted therefore as comprising lay and professional medical education, sanitation, preventive medicine, curative medicine, dental and nursing care, and pharmacy.

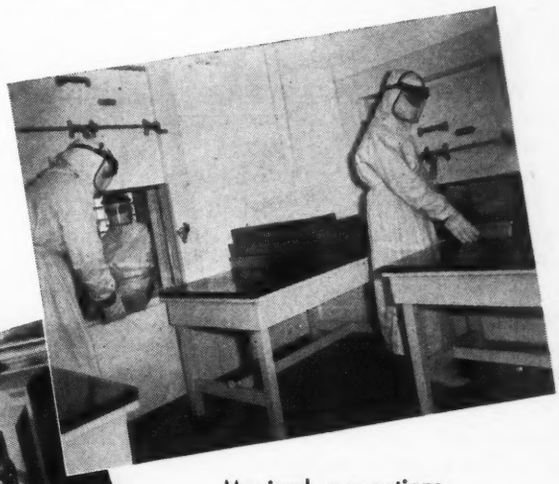
"It is evident that there exist today and, in view of the rapid advances in medical science, that there will always exist difficulties in making available to all the highest standard of medical care. *It would be the function of such a committee as we propose to be constantly comparing what is available in the way of medical care in our state with what is known to be valuable and to plan systematically to repair the deficiencies in our present system.*"

Form Medical Planning Agency

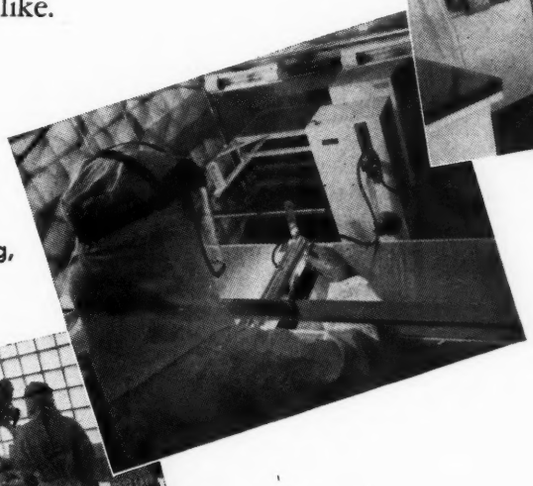
As a result of this suggestion, the committee on medical care of the Maryland State Planning Commission was formed. Representatives of all segments of the Maryland community were included thereon, although the intensive work was done by representatives of medicine, hospitals and agriculture.

In spite of the handicaps imposed by the war years, this committee has made, and is making, an impressive record of accomplishment. After an

The meticulous care exercised in manufacture — the safeguards against contamination provided at every step in production — the painstaking biologic and bacteriologic assays of the finished product, are reflected in the wholehearted acceptance of Penicillin-C.S.C. by physicians and hospitals alike.

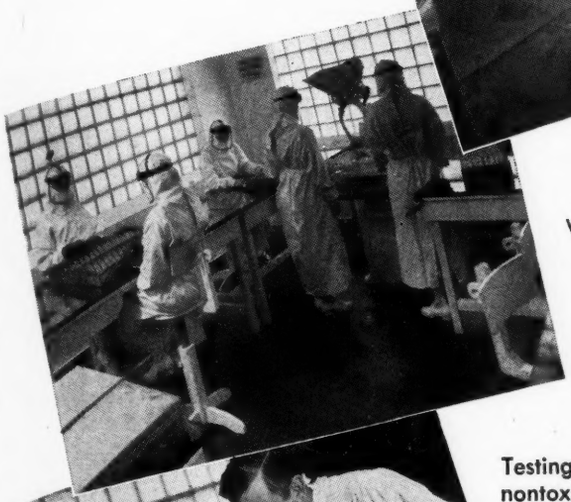


Maximal precautions maintain sterility

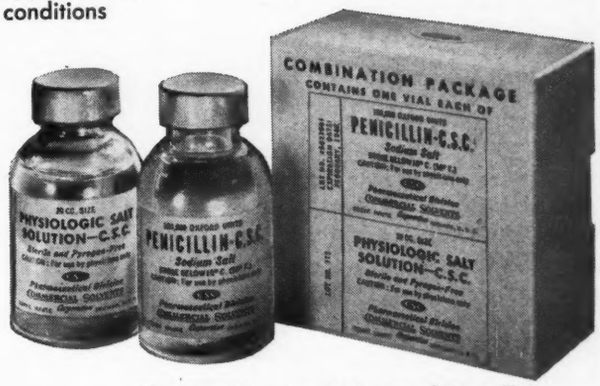


Note masks, sterile clothing, gloves, glass screens

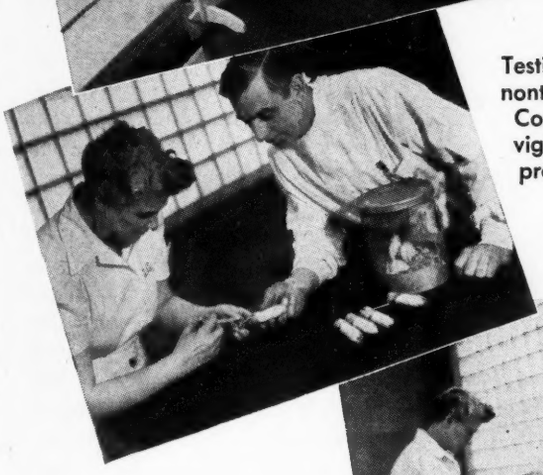
CSC



Vials are capped under optimal conditions



The Combination Package of Penicillin-C.S.C. and Isotonic Solution of Sodium Chloride



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initial review of its responsibilities, the committee decided to concentrate its first efforts in the counties of Maryland, feeling that there the needs were more acute. The comprehensive survey of the counties has resulted in the following actions thus far:

1. Enabling legislation and appropriations for the construction of three state-financed chronic disease hospitals.

2. Adoption of a state-financed program for providing medical, surgical and hospital care to the indigent and medically indigent of the counties. The responsibility for developing and administering this program has been given to the state health department. For the first time we find a state health department legislatively charged with the responsibility for developing a program of curative medical care.

$200,000 Appropriated

Under this legislation, which became effective June 1, 1945, the directing body has been formed, an executive has been employed and programs in the various counties have been initiated. A state appropriation of $200,000 a year for the first biennium has been made. Also, under the responsibility of this new "bureau of medical care" in the state health department has been placed administration of the chronic disease hospitals when completed.

It is expected that enough experience with its administration will have been gained during the current period of light public assistance loads so that as these approach their normal peace-time levels the program can effectively assume these increasing burdens. It is likewise anticipated that the present program of state appropriations to the voluntary hospitals for the care of the indigent may be placed under the same authority.

The whole program is based on the philosophy that, if existing health service agencies are relieved of the financial drag imposed by the care of persons who are otherwise the responsibility of public assistance, the quality of service rendered by such voluntary health services to all their patients will be materially increased.

3. Accumulation of a series of suggestions looking toward the better integration of the medical care facilities in Baltimore city and the counties, the adoption of which must await the return of our war economy to normalcy.

Under the aegis of this statewide committee, a special committee was created last year to attack the medical care problems of Baltimore city. Under its sponsorship a searching survey is now under way and comprehensive recommendations may be expected from it.

In 1940 representatives of the hospitals in Maryland and the District of Columbia formed the Maryland-District of Columbia Hospital Association, which has been active in improving the standards and increasing the effectiveness of the hospitals in Maryland and the District of Columbia. At its instigation a program for licensing all institutions giving care to bed patients has been enacted and soon will be in operation.

The object of this program is to encourage all existing institutions to raise their standards to acceptable minimums. When this is not possible, however, the law provides adequate enforcement authority to ensure compliance in the few instances where its objectives may not be voluntarily accepted.

A long-range program of construction and expansion of services has been developed by the State Board of Mental Hygiene. This program, after review by the committee on medical care of the State Planning Commission, has been adopted in large part by the fiscal authorities of the state. Major additions to the plants available for the care of psychiatric patients are planned as an early part of the state's postwar construction program. Included in this program is the addition of a psychiatric pavilion at the state-supported University Hospital.

Question of the Month

Space limitations preclude the publication of the Question of the Month in its customary space on this page. It will be found this month on Page 86.

Under the sponsorship of the Baltimore Hospital Conference, a survey of the general hospitals in Baltimore has been undertaken. With these data individual institutions can evaluate the remodeling and reconstruction that are scheduled to begin when material and labor are available.

At least six of Baltimore's 18 voluntary hospitals have specific plans for major construction in the immediate postwar period. A channel is therefore provided whereby this construction can be planned to meet the city's total needs most effectively, with as little overlapping and duplication of facilities as possible.

Perhaps the most far-reaching development in recent years in Maryland has been the decision of several county health departments to locate in the general hospital buildings. This physical proximity of the local centers of curative and preventive medicine as we know them today should do much to break down the artificial barriers between these two segments of health service.

This Shows What Can Be Done

Here then, in broad outline, we have an example of a typical state in which government, the medical profession and the hospitals are learning to work together effectively —not because of any legislative fiat to do so, but as a result of a common recognition that their services to citizens and patients can be more effective when coordinated at the points where coordination will produce results.

Any attempt, based on our present limited experience, to introduce a full-blown national health program into our present health economy could only result in "freezing" our knowledge of health administration for a long period of time at its present inadequate level. The British difficulties in trying to change from the "panel system" long after its inadequacies had been generally recognized is an example of this congealing tendency that is inherent in any legislatively enacted program.

Our present efforts would seem more wisely directed when focused upon the stimulation of cooperation among the various segments of health service at the local level. The experience in Maryland indicates that this hope can promptly be translated into action and achievement.

Where Are Our Standards?

HAZEL E. LANDEEN
Graduate Student
University of Minnesota

ONE is entitled to speculate on the reasons underlying some recent legislative proposals to "protect" the public from the use of certain agents (established as household remedies) which through improper application have produced death in a few isolated cases. It would seem that such restrictions could be aimed at preventing the use of these remedies through legitimate professional channels and thus discrediting the professional purveyors.

It goes without saying that in the handling, dispensing and use of any substances to correct bodily discomforts or morbidity caution *is* required. Pharmacy, out of regard for its code of ethics and in compliance with state laws, is fulfilling its obligations. But when we have dinned into our ears daily the manifold blessings of various products heartily endorsed by "nurses and hospitals" we seek a correlation between such endorsements and the prevailing custom of preventing accidents through use of coloring agents intended to serve as visual reminders that precautions are to be observed.

The reason for the precaution is commendable but is in itself an admission of a lack in the training of the persons who are permitted to prepare and administer these substances.

Why Are Controls Needed?

The existence of or need for such controls (oversimplified in many instances) forces an inquiry into the causes necessitating these steps. The reasons may best be summed up under one heading: indifference on the part of the administration as to the legal and moral responsibility of the hospital in the purchase, storage and dispensing of drugs and chemicals. This indifference has led to either: (1) inadequate personnel or (2) personnel assuming duties and responsibilities for which it is neither trained nor licensed.

The hospital that fails to provide adequate and trained assistance for its pharmacist is morally as negligent as are those hospitals that delegate the supervision of their "drug rooms" to a nurse or other laboratory workers who have had only a nodding acquaintance with drugs.

It may not be out of place to point out that almost any lay person can give himself insulin, can administer an enema, massage a tired back and change an invalid's bed but no one regards these performances as embracing the entire field of nursing. Just so, no pharmacist regards the ability to read the wording on a bottle and pour therefrom or the mixing and coloring of a few simple solutions as embracing the art of pharmacy!

Professional people are, or should be, the backbone of any community. The nature of their work lies in the betterment of human welfare. One recognizes this from the definition of hospital standardization given in the "Manual of Hospital Standardization" of the American College of Surgeons, namely, "a movement to encourage all hospitals to apply certain fundamental principles for the efficient care of the patient which are set forth in the minimum standards for hospitals.

"Its object is to promote better hospitalization in all its phases in order to give the patient the greatest benefits that medical science has to offer. Its aim is to create in the hospital an environment which will assure the best possible care of the patient. This involves facilities, personnel and procedures predicated upon efficient organization, progressive management and competent personnel imbued with a scientific and humanitarian spirit. When an institution adopts and successfully applies the above named principles which express the high standards of modern medical and hospital practice it is known as a standardized or approved hospital."

One pauses to ask: Where are our minimum standard hospital pharmacies required of all accredited or approved hospitals? It appears that good intentions have not succeeded in setting up many!

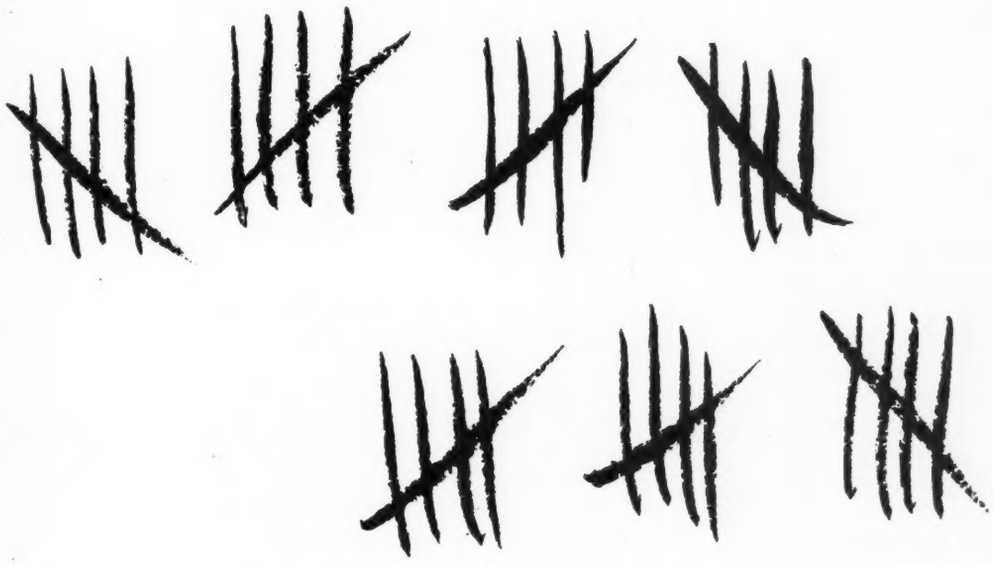
Quoting again from the manual: "The fundamental idea is that the individuality of the hospital must be conserved. While the scientific aspect of the present day hospital is most important, it must not completely overshadow the humanitarian spirit of the institution. The patient in a hospital is an individual and, therefore, he cannot be standardized. Rather, he must be individualized in diagnosis and treatment and he must never be considered as an inanimate number or merely as one of a group."

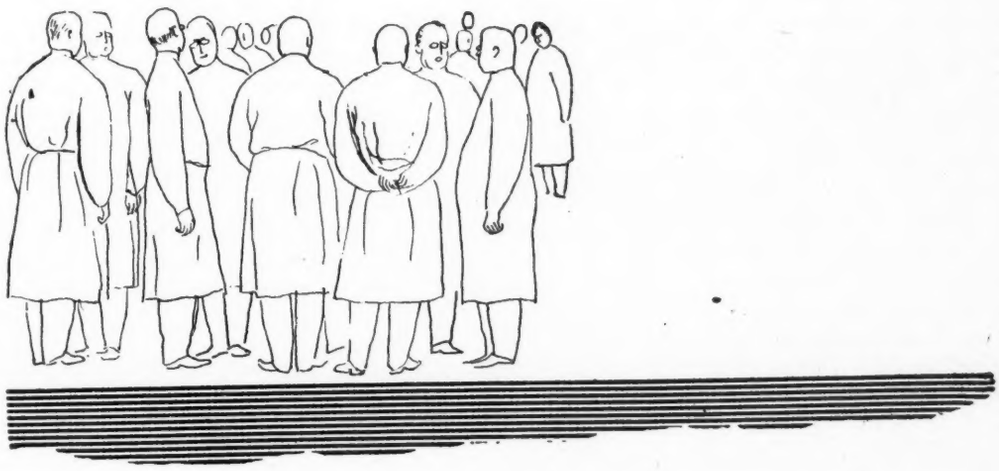
Humanitarian Attitude Wanting

There is, undoubtedly, little room for complaint on the part of most hospital patients as to quality of care received although we recognize that good care of the sick may not always be motivated by scientific and humanitarian reasons. It has often occurred to me that administrative understanding, consideration and treatment of hospital personnel were seldom based on scientific precept. Because of this lack the humanitarian attitude toward personnel is often wanting.

How many administrators, for example, have considered the vicious effect on the output and quality of work of the hospital pharmacist attempting to breathe in a basement "fox hole"? How many administrators could do their job efficiently given the physical setup of the majority of our hospital pharmacies?

35 years among the first





In 1910, an assemblage of experts ranked ether first among the ten most important drugs. In 1945, a similar compilation shows ether still crowding even penicillin, the sulfonamides, and anti-malarials for top rank. Thus after 35 years, ether retains a place among medicine's most important agents.

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MANUFACTURING CHEMISTS TO THE MEDICAL PROFESSION SINCE 1858

The stagnation in many of our hospital pharmacies may be likened to a varicosity. In spite of handicaps, hospital pharmacists continue to make sporadic attempts to improve their services and demonstrate their indispensability. These attempts often result in a dilatation of hope and effort, are often frustrated and rendered stagnant. Occasionally they are relieved by periodic outbursts of good intentions on the part of the administration. At such times the stagnant mass again moves forward in the right direction.

Hospital pharmacists have been earnest in their attempts to convince hospital administrators that they have a training from which the hospital stands to benefit. It seems to me somewhat naïve to try to *justify* the existence of a pharmaceutical service in hospitals when most state laws and hospital standards already have indicated that such a service is to be established and maintained.

Pharmacy comprises the art and science of collecting, identifying, preparing, preserving, evaluating, compounding and dispensing drugs and medicines. Pharmacists must prove their qualifications before state licensing boards. They are members of a profession subsidiary to the medical practitioner in their capacity of compounders, dispensers of prescriptions ordered by the physician, *qualified by education,* training and *official recognition* to prepare, compound and dispense drugs, medicines and chemicals required by the public. Certainly, no further argument should be required to convince hospitals that pharmaceutical service is a legal responsibility.

Pharmacists Urge High Standards

Hospital pharmacists, individually and as a group, have long pointed out the advantages that accrue to the hospital that maintains a system of stock control, supports a pharmacy committee and abides by its findings. It is fitting at this point to indicate that these two requirements are among those required in the minimum pharmacy standards by the American College of Surgeons and that they were evidently the result of considerable study on the part of the committee that drew up the requirements!

Added proof is available for comparison of costs of operation of hospital pharmacies that are conducted in accordance with these hospital pharmacy standards with those of pharmacies operating under the too prevalent system of chaotic empiricism. Hospital administrators interested in a more complete utilization of the potential possibilities of a hospital pharmacy should reread and study the report entitled "Costs of Medicine" that was prepared for the Committee on the Costs of Medical Care and published by the University of Chicago Press, 1932, under the joint authorship of C. Rufus Rorem and Robert P. Fischelis.

Upon enlightened leaders in the hospital field rests the obligation for bringing into existence a genuine education for pharmacists in their professional responsibilities within the hospital and the community; for clarifying the confusion in our thinking relative to boundaries of the various specialties operating within the hospital (and thereby removing the deadly poison of fear and distrust); for defining and nourishing professional responsibility and pride in the pharmacist as contrasted to professional "bootlicking."

The G.I. and Hospital Pharmacy

HENRY M. BURLAGE
Professor of Pharmacy
University of North Carolina School of Pharmacy

MANY universities and colleges throughout the country have long had committees on postwar planning engaged in studying and proposing courses of study for the returning veterans who wish to take advantage of the educational opportunities under the G.I. Bill of Rights.

In line with these studies and in order to obtain some information as to how many pharmacists and undergraduate students of pharmacy in the armed services might be interested in these opportunities, a questionnaire was prepared by the secretary of the North Carolina State Board of Pharmacy, the secretary of the North Carolina Pharmaceutical Association and the staff of the school of pharmacy of the University of North Carolina.

Two types of offerings in hospital pharmacy were listed in the questionnaire: (1) a training course in hospital pharmacy and (2) an advanced degree in hospital pharmacy. Of the 53 replies received, four undergraduates expressed interest in working toward a degree in hospital pharmacy; two indicated a desire for advanced degrees in this branch of study.

Training Course in Hospital Pharmacy

One person indicated this as first choice, with six months' training.

Seven persons indicated this as a preference without qualification; three want it for three months; one, for six months; two, for one year; one, with no time limit specified.

Nine individuals indicated this as a second choice: two, for three months' training; two, for six months'; two, for nine months'; three with no time limit specified.

Thus, 21 persons checked this offering, with most of them indicating, at least, a desire for three months' training.

Advanced Degree in Hospital Pharmacy

Three individuals indicated this as a first choice; one, as a second selection; three, as a third choice; one, as the fourth preference.

This interest in hospital pharmacy came as a distinct surprise to the group sending out the questionnaire. If this response is considered on a nationwide basis it is probable that there is a sizable group of persons in the armed forces that would like to take up this branch of professional practice.

If this interest materializes and if the demand for hospital pharmacists continues to increase, adequate programs should be developed in order to place the discharged veteran properly in this rapidly growing field. Persons with three types of previous

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INDICATED in the treatment of both spastic and atonic constipation, and as an adjunct to dietary measures for the control of constipation in aged, convalescent and pregnant patients... those with hemorrhoids, and with erratic dietary habits.

DOSAGE: One or two teaspoonfuls once or twice daily, along with ample liquids to assure maximum bulk formation. *Unflavored*—Mucilose mixes well with any fluid ...sweet or salty...to suit any taste. Placed on the tongue and washed down with water, or eaten along with other foods, Mucilose—because it contains no diluents—has no flavor to be disguised.

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training might wish to take such a program:

1. The registered pharmacist who has already had some practical experience and may even have been stationed in an Army dispensary.

2. The individual with a B.S. degree in pharmacy but who has not become registered because he has not had the practical experience. The best recommendation for this man would be to take an internship in a hospital pharmacy where the internship would count toward experience in order that he may become a registered pharmacist. He may also have had some experience in a dispensary while in service.

3. The undergraduate who has not completed his studies for the B.S. degree in pharmacy. He should be advised to finish this curriculum and then take hospital pharmacy in the form of an internship so that this work can be counted for his experience in order that he may become registered.

The following programs depending upon the facilities available have been suggested:

1. Schools of pharmacy located at universities or colleges that have hospitals with pharmacies. This would seem to be the ideal situation for such a program. The necessary didactic instruction could be given in a school of pharmacy by properly trained instructors in conjunction with practical training in the hospital pharmacy for three or six months as desired, or instruction leading to a graduate degree in hospital pharmacy might also be offered.

2. Schools of pharmacy with hospital pharmacy affiliations in hospitals in near-by areas. These schools, while not as ideally situated as those above insofar as hospital pharmacy is concerned, might offer didactic work as an intensive course preceding the practical work in the hospital pharmacy, which would be affiliated with the school. A three or six months' period of training would seem the most feasible although, if adequate transportation facilities between school and hospital are available, an advanced degree in hospital pharmacy might be offered.

3. Schools of pharmacy without hospital connections or affiliations. These schools could develop fairly satisfactory didactic instruction and certain phases of manufacturing as done in connection with hospital pharmacies provided the equipment is available. This might include a three months' or six months' or even a graduate program.

4. Some reliable person, such as the secretary of the state pharmaceutical association or the secretary of the state board of pharmacy, might sponsor correspondence study in the didactic work and place the applicants in hospital pharmacies that would be willing to cooperate.

There may be more feasible plans of instruction for this group of discharged veterans and these I shall welcome. Since there will be a shortage of registered pharmacists for a considerable time, it would seem wise for those hospitals with pharmacies to cooperate in this work to be assured that the men who do enter the field of hospital pharmacy have the proper preliminary training. In fact, it seems apparent that the hospital cannot afford to risk employing a person who has not had this form of instruction.

This program of training for returned veterans will be discussed further in future issues.

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2. Markedly light in color.

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BRISTOL PENICILLIN

*Keys, J.E.L.: Penicillin in Ophthalmology. J.A.M.A. 126: 610 (Nov. 4) 1944.

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Iron and Anemia

A. J. LEHMAN
Department of Pharmacology, University of North Carolina

IRON preparations have been employed therapeutically for many years. The ancient Hindus treated anemia with iron salts on an empirical and perhaps even allegorical basis, since the existence of iron in the blood was not demonstrated until the work of Lemery and Goeffy in 1713. Bland in 1831 gave the first clear-cut definition of chlorosis as a disease resulting from an inadequate formation of the coloring matter of the blood. He contended that large doses of iron, akin to those used today, were necessary for satisfactory treatment of the disease.

Sydenham had stated the need for large doses as early as 1681 but in those days of intuitive medicine any divergence from standard methods was not always accepted. Thus, before the middle of the last century the foundations had been laid for the erection of an entirely satisfactory treatment of the iron-deficient anemias. Before the structure was completed the work was discredited by men who taught that iron was useless in anemia since they failed to obtain results with small doses.

When the use of iron again came to the fore a long and bitter controversy arose as to the relative merits of organic and inorganic forms, although the terms un-ionizable and ionizable would better convey the nature of the contention. The controversy ended with the demonstration that only ionizable iron was absorbed in significant amounts and that the ferrous iron was much more readily absorbed than the ferric ion.

Utilization

Whipple and his co-workers, by using radioactive ion, have shown that the amount absorbed varies directly with the organism's need for the element. On the same dosage an anemic animal may absorb 70 times the amount absorbed by a nonanemic animal. This indicates that iron metabolism is controlled by absorption rather than excretion.

The percentage of orally administered metal assimilated varies inversely with the size of the dose but even with very small doses only a portion is absorbed. The hydrochloric acid of the stomach and the biliary secretion appear to favor the uptake of iron, the former because it increases its solubility and ionization and the latter for an unknown reason. Absorption is by way of the intestinal capillaries and not by the lymphatics.

After the organism's storehouses for iron have been filled little more iron enters the system. The chief storehouses are the organs rich in reticulo-endothelial cells: liver, spleen, bone marrow and, to a less extent, the kidney. Somewhat more than half the body's iron is in hemoglobin. About 7 per cent is in muscle hemoglobin; there are small amounts in the plasma, 0.05 to 0.18 mgm. per cent, according to Moore and his co-workers. The remainder is widely distributed.

The normal fecal excretion of iron is from 10 to 20 mgm. per diem. Welch and Maddock and their co-workers cast grave doubts on the traditionally accepted colonic excretion of iron. Urinary excretion is negligible, as is biliary. Hahn and Heath and Patek have esti-

Dosage of Iron Preparations

Preparation	*Daily Dose Grams*	*Mgm. of Iron*	*Approx. Amt. Utilized in Mgm.*
Ferrous sulfate (hydrous).....	1	200	30
Ferrous carbonate (pills).....	4	360	25
Reduced iron.....	3	2700	23
Iron and ammonium citrates.....	6	1000	23

mated the total iron of the body at about 4.3 grams.

Types of Medication and Dosage

In the use of iron in treating hypochromic microcytic anemias one must keep two points in mind: first, the dose of iron must be large if it is to be effective and, second, the soluble ferrous salts are more readily absorbed. The use of reduced iron, for example, is irrational because if the metal is to be utilized at all it must be rendered soluble by reaction with the hydrochloric acid of the stomach and frequently the patient with secondary anemia is deficient in hydrochloric acid.

The most satisfactory preparation is ferrous sulfate. Organic preparations of iron are needlessly expensive. The oral route should be used for the parenteral route is painful and may be dangerous. In emergencies the iron may be given intramuscularly and for that purpose the ferrous gluconate and iron adenylate are less irritating and toxic than are the official green iron and ammonium citrates.

The dosage of the commonly used iron compounds as recommended by Strauss is given in the accompanying table.

A glance at the table indicates at once that all of the iron salts are useful therapeutic agents provided they are given in adequate dosage. The assimilation of about 25 mgm. of iron represents a rise of 1 per cent in hemoglobin. The use of copper for enhancing the hemopoietic action of iron is not justified by the experimental evidence available. Copper is so widely distributed in the dietary and is so frequently a contaminant of iron preparations that the patient is sure to get a sufficient amount.

Toxicity

The systemic action of iron is similar to that of arsenic. However, this is of no significance since at least 60 mgm. per kilo of the metal must be given parenterally to produce such effects, which represents about 150 times the daily therapeutic dose by the same route.

An appreciable number of patients, actually one in three, respond to ferrous sulfate with gastro-intestinal disturbances characterized by diarrhea, colicky pain and gastric distress. Less often there is constipation. This may occur even when the iron is given after meals, the time of choice.

A temporary reduction in dosage or a shift in preparation usually gives satisfactory results. Iron gluconate is one of the newer compounds which can be substituted in the more sensitive patients.

Summary

Iron deficiency anemia may be treated with any salt of iron. The ferrous salts produce a better response than do the ferric salts, dose for dose. The amount of the metal utilized determines its usefulness and not the percentage composition with reference to iron in the compound. About three times the dose of ferric iron is required to equal the response of ferrous salts. Some of the un-ionized salts of iron, such as the ferric ammonium citrates and iron glu-

conate, may be substituted for the ferrous salts if gastrointestinal disturbances preclude the use of the latter. Unless the patient is too ill to take iron orally parenteral administration is not justified.

CLINICAL BRIEFS

Conducted by E. M. Bluestone, M.D.

Ward Care of the Chronic

Admission to a hospital has many implications besides the determination of the causes of disease. Malcolm Brown and Freda C. Carling in the *British Medical Journal* (7:478-481 [April] 1945) have raised the question as to the value and efficiency of a general medical ward. The investigators proposed to discover how hospital illness is met by the patient.

The material for their study consisted of 156 patients admitted over a period of six months. Collier Ward of the Radcliffe Infirmary, Oxford, which has a capacity of 21, equally divided between the sexes, was the site of the experiment. The medical and nursing staff consisted of a house physician and seven nurses. The room cost was approximately $10,000 for the period.

A questionnaire was sent to all the patients who had been in the ward. All of the patients were civilians but five; 10 per cent were evacuees from London. While most of the patients came from Oxford, 8 per cent came from areas at a considerable distance from the hospital.

An analysis of the data collected reveals some facts of interest to the hospital executive. During the six months' period under investigation, 26 per cent (39 of 156) of the patients were cured; 19 per cent (29) of the patients died; 55 per cent (82) were still suffering from the disease which had caused the admission; 5 per cent (8) were incapacitated because of psychogenic symptoms; 21 per cent (32) were admitted to other hospitals; 32 per cent (38) were in need of the care in the out-patient department; 25 per cent (10) were getting the care.

During the six months' period only 39 were classified as cured. From a social point of view, hospitalization was beneficial to the surviving patients. While 26 per cent were considered medically cured, 48 per cent were able to return to full-time work and 20 per cent resumed part-time work.

A study of these patients on an age basis showed that those under 40 years returned to full work more frequently than those in the higher age groups. Judged on length of stay in the hospital and the duration of an illness the data revealed that those who remained in the hospital less than three weeks and those who were ill for less than three months had a better chance of recovery than the others.

Perhaps the most significant conclusion reached by the authors from their studies on the limited group of patients in a more or less restricted location is the fact that 70 per cent of the patients required medical supervision after discharge. This, obviously, is an inherent defect in all general hospitals where provisions are made only for short-term patients. The long-term patient and his needs are met today in few hospitals. The patient is referred back to the private physician and ultimately readmitted.

The number benefited by hospital care is small and presents cogent evidence for the care of the chronic or long-term patient in conjunction with general hospitals for the acutely ill.—Michael Levine.

Christmas Calls for Preparation

J. MARIE MELGAARD
Administrative Dietitian, St. Luke's Hospital, Denver

HOLIDAYS, particularly Christmas, mean more work for everybody in the food service department, but they also mean more fun for everybody when each person feels that he has some part in creating the Christmas spirit. No one even minds the extra work involved in the preparations when it is all planned beforehand and each person knows what he has to do and when it is to be done.

I usually make my schedules out a month ahead and copies are given to the supervising dietitians and cooks. Instructions are given to employes in group meetings.

The following work schedule is somewhat simplified inasmuch as it was worked out during war time. Perhaps that is just as well because, probably, most hospitals still do not have the necessary help to make many extra preparations.

It will be noted that these preparations entail dining room service for the staff and employes. Even in hospitals that have cafeteria service it is nice to have waitress service for a holiday dinner if possible.

MENU

Tomato-pineapple juice cocktail
Celery hearts Olives Crabapple pickles
Plantation turkey with trimmings
Snowflake potatoes
Buttered lima beans
Buttered English peas
Cranberry sauce
Parker House rolls
Tossed green salad
Old English plum pudding with hard sauce
Neapolitan ice cream
Assorted fruits Nuts Dates
Black coffee Sweets

SCHEDULE OF WORK

PLANNING AND PURCHASING

Make out requisitions and market lists, including date to be delivered, amount, unit price and cost.

Food
- Groceries
- Canned goods
- Fresh fruits (to be delivered on December 22)
- Fresh vegetables (to be delivered on December 22)
- Turkeys (to be delivered on December 22)
- Dairy products
- Rolls and crackers
- Miscellaneous

Extra Dishes and Silver
- Patients' food service: private rooms and wards
- Dining rooms

Decorations (General)
- Favors: patients'; special diets; dining rooms; night lunch
- Tray covers: patients'; special diets
- Napkins: patients'; special diets; dining rooms; night lunch

Decorations (Dining Rooms)
- Christmas trees: one large (10 feet); one small (3 feet)
- Pine boughs
- Holly
- Icicles
- Red cellophane
- Red ribbon
- Red, white and blue tapers, 15 inch (two for each table)
- Large wooden bowl of fruit with popcorn balls

EMPLOYING HELP

Rescheduling Day's Work
- General kitchen
- Dining rooms
- Extra help, if necessary

ADVANCE PREPARATION

Week Before
- Make candy and store in tin cans
- Stuff dates, salt nuts and store in tin cans
- Prepare candied fruits for plum pudding
- Make wreathes and store in refrigerator
- Sort decorations

Thursday Before
- Make plum pudding

Friday Before
- Decorate Christmas trees and windows
- Wrap candle holders

Saturday Before
- Make popcorn balls
- Make cranberry sauce
- Clean turkeys

Sunday Before
- Polish fruit
- Get all decorations together

Day Before
- Count tray covers and napkins for patients' trays
- Count napkins for dining rooms
- Count and fill nut cups; arrange on trays for different units
- Prepare fruit trays for ward floors
- Prepare large fruit bowl for dining rooms
- Clean and prepare vegetables

Special Directions

MENU GIVEN TO COOKS

Tomato-Pineapple Juice Cocktail	Half and half
Celery Hearts	Use inner stalks for relish, dip end in paprika, use outer stalks for stuffing
Olives	Stuffed and ripe
Crabapple Pickles	Home preserved
Plantation Turkey	Bake with one strip of salt pork over each turkey
Stuffing	Use cubed bread, apples, celery, raisins and a little sage; bake stuffing in birds; serve with a No. 10 scoop and place turkey slice on top—1 slice white meat and 1 slice brown meat
Giblet Gravy	Use giblet stock for part of liquid and add chopped cooked giblets
Snowflake Potatoes	Put through the larger ricer
Buttered Tiny Lima Beans	Frozen
Buttered English Peas	Canned
Cranberry Sauce	Serve in small soufflé cups
Parker House Rolls	Put in oven before serving
Tossed Mixed Salad	Lettuce, curly endive, cucumbers, radishes, to be put in glass bowls on tables or large salad bowl on counter
Old English Plum Pudding	Serve hot with hard sauce
Hard Sauce	Flavor with rum extract
Assorted Fruits	Grapes, oranges, apples, bananas, grapefruit, tangerines, pears—for large wood bowl and trays to patient floors
Nuts	Salted pecans
Dates	Stuff with pecan and roll in granulated sugar
Sweets	Home-made fudge and divinity, hard candies, gumdrops
Black Coffee	

DIVISION OF WORK

Directions to Cooks

Copy of menu
Recipes to be used
Amounts to be prepared for: patients (house, light, soft, special diets); dining rooms; night lunch

Decorations (Patients')

Prepare tray covers and napkins for each tray
Place favors on each tray
Send up tray of fruit to each ward floor on Christmas morning, to be taken up by tray girl at 9:15 a.m.; use small trays with Christmas covers

Decorations (Dining Rooms)

Set up large Christmas tree in each dining room — south center wall with fireplace background; place one tree in nurses' dining room and one small tree on extra table in doctors' dining room; decorate with colored lights, ornaments, tinsel, popcorn strings and snow
Bring in pine boughs and holly with red cellophane to be hung at windows
On table near door place wooden chopping bowl filled with apples, oranges, grapefruit, tangerines, bananas, grapes and popcorn balls; surround bowl with circle of red, white and blue tapers set in glass holders; decorate with sprigs of pine and holly
Hang large wreath at entrance to dining room

Food Service—Patients'

Instructions for counting out and arranging utensils and dishes
Organization at each serving center
Assignment of special duties to workers at the serving center
Set up sample tray with decorations Sunday a.m. and serve sample plate showing arrangement of food on the dinner plate, Sunday a.m.

Food Service—Dining Rooms

Organization at the serving center
Set up sample plate showing arrangement of food on dinner plate, Sunday a.m.
Directions to waitresses
Copy of menu (memorize)
Directions for setting tables
Decorations of tables: use white linen table cloths; two candles (red, white and blue) on each table; place sprigs of pine and holly around each candle holder; place filled nut cups at each cover, top center; place Christmas napkins left side of each cover
Set up tables in usual way and order

Serving Each Course

Place small relish dishes with celery hearts, olives and crabapple pickles and salad bowl on each table at 11:20 a.m.
Dinner
First course: Place cocktail in fruit juice glasses on bread and butter plate lined with Christmas doily on tables at 11:25 a.m.
Second course: Dinner plate to have turkey, stuffing, gravy, potatoes, lima beans or peas, cranberry sauce in soufflé cup and roll
Third course: Dessert: plum pudding, served hot, with hard sauce; coffee may be served with the main course or with the dessert

MEMORANDA

Small servings of everything, but generous portions of turkey
Extra people to be served in dining rooms: interns' wives; business office staff; engineers; janitors; ward maids; housekeeping maids; laundry crew
Decorate tables after 8 a.m. Christmas morning; set up table in dining room as sample on Sunday a.m.

OTHER CHRISTMAS MEALS

Christmas Eve Dinner

Patients: chicken à la king
Dining rooms: fresh ham
Tree center ice cream and fruit cake
Fruit cake arranged in circle on green doily on dinner plate for each table in dining room, with sprig of holly in center of plate

Christmas Morning Breakfast

Use Christmas napkins and sprig of holly on each patient's tray

Christmas Day Supper

Patients: corn chowder with popcorn sprinkled on top
Dining rooms: oyster stew, assorted sandwiches, potato chips, fresh fruit, Christmas cookies in shape of Santa Claus, pine tree and star sprinkled with brown sugar or decorating candies.

If You Are Planning a Kitchen

ROBERT J. REILEY
Architect, New York City

THE accompanying diagram shows a typical layout for the dietary department of a general hospital of about 200 beds. In its preparation, special emphasis has been placed on the proper relation of each part to every other part because the smooth functioning of the entire department depends largely upon it.

The other point of emphasis is the routing of food from the time the raw material enters the building until it reaches the patients or the staff so that there will be no backtracking or crossing of traffic.

There are several methods of serving meals to patients. For this study it was assumed that the trays would be made up in the main kitchen, under the supervision of the dietitian, sent up in trucks on the service elevator to the various floors and immediately delivered at the bedside. The soiled dishes would later be collected on the same trucks and conveyed to the dishwashing department near the main kitchen.

After being washed, the trucks would then be ready to receive the tray setups for the next meal, when needed. When using this system, provision must be made for the storing of the trucks between meals; otherwise they are likely to be left in corridors or be generally in the way.

Nurses and employes are served from the one pantry without coming in contact with one another.

A separate refrigerator is provided for "leftovers" which is a great convenience and in line with the present day conservation of food.

Storerooms are in a separate wing but are readily accessible to the kitchen and their location on the ground floor eliminates transporting material down to cellar storerooms and up again to the day storeroom.

The author wishes to acknowledge the cooperation of Dr. C. W. Munger and M. A. Mosso, administrator and dietitian, respectively, of St. Luke's Hospital, New York City. This article also appears in the twenty-third edition of the Hospital Purchasing File.

Dietetics as an *Art*

CORA E. KUSNER

Chief Dietitian
Colorado State Hospital, Pueblo

THE American Dietetic Association defines a dietitian as "one who has had college training in the *science* of nutrition and management and is proficient in the *art* of feeding individuals and groups." Just what is meant by "the art" of feeding people?

A man sat down at a lunch counter and ordered coffee and doughnuts. The waitress filled his order but a minute later, in wiping off the adjacent counter area,. swished one of his doughnuts off onto the floor.

"Say," he expostulated, "I had just two bites out of that doughnut!"

Whereupon, without a word, the girl reached for a fresh doughnut, took two bites out of it, put it on a plate and shoved it over in front of him! Scientifically she had replaced his loss, but neither artfully nor skillfully.

Not Enough Consumer Appeal

Too often our hospital food problems are handled just like that—too much emphasis on accuracy and not enough thought about "consumer appeal." The administrative dietitian spends her time planning work schedules and job specifications, buying and requisitioning, making budgets and keeping records. In some hospitals the dietitian is expected to be accountant, bookkeeper, typist and her own secretary. Hospital administrators would do well to realize that they can hire someone to type menus and keep records at a much lower salary than is paid the average dietitian.

The therapeutic dietitian fills the doctors' dietary prescriptions by planning scientifically correct menus in accordance with the latest findings in diet therapy research. The teaching dietitian interests herself primarily with instruction in diet in disease.

Meanwhile, the actual end product of all this effort, the food on the patient's tray, may be palatable or not, depending upon the efficiency of Mary the cook or Susie the tray girl or whether or not the nurses on the floor serve the tray promptly and a dozen other factors. All of the scientific skill used in planning the diet may be wasted because when the actual food reaches the patient it neither looks nor tastes good.

She Must Be a Good Cook

As a basis for proficiency in the art of feeding individuals or groups, a dietitian needs three special skills. First, she must be skilled in the art of good cookery. The hospitals or institutions in which the full responsibility for food preparation can be left to the skill of a trained chef are few and far between. There are not that many really good cooks; if there were, hospitals do not pay enough to get them.

Training cooks not only in the newer cookery methods to preserve nutritive value but also in the preparation of food that is "good to eat" is certainly a major part of the dietitian's responsibility. Timing of cooking, seasoning, garnishing, all are a challenge to the skill of any food administrator.

As with any art, "food sense" does not reach its highest development in four or five years of school and training. Skill comes with constant interest and practice in evaluating flavors, food combinations and technics of preparation. Not only must the dietitian have high food standards, she must be able to help others to achieve them.

Second, the successful dietitian must be skilled in the art of getting along with people. Perhaps I should have discussed this point first! Ask any hospital administrator what is his chief problem and nine times out of ten he will tell you that it is adjusting difficulties among individuals and integrating the work of his various staff members.

It is perfectly natural for dietitians to think that the dietary department is the most important part of the hospital, but they need to remember that the head of every other department feels the same way about his or her own particular specialty. Getting along with people in the hospital organization has a great many aspects.

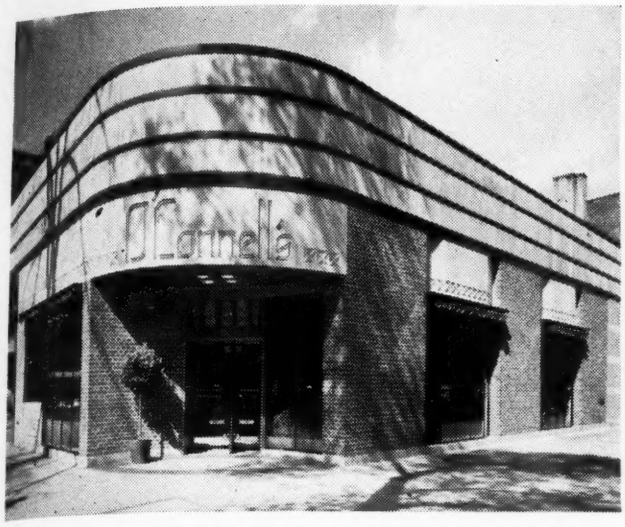
Friction between the nursing staff and the dietary department is commoner than those of us who are thoughtful like to admit. Instead of making every effort to alter the situation, too often we treat it as a joke and go on allowing minor irritations to hamper the efficiency of both departments.

Psychology Is Part of the Job

Personnel problems are sometimes aggravated because dietitians in administrative positions fail to take cognizance of the basic psychology that affects the relationship between employer and employe. If part of the dietitian's job is to handle other people, attempting to do it without a knowledge of the universal human wants and motives which affect her workers is like attempting to do any other work without having the proper tools.

Personnel management decidedly comes under the heading of the art of getting along with people and is important to the dietitian whether she deals with one tray girl or is head of a large department. Employes are actually the tools with

Presented at the meeting of the Colorado Dietetic Association, 1945.



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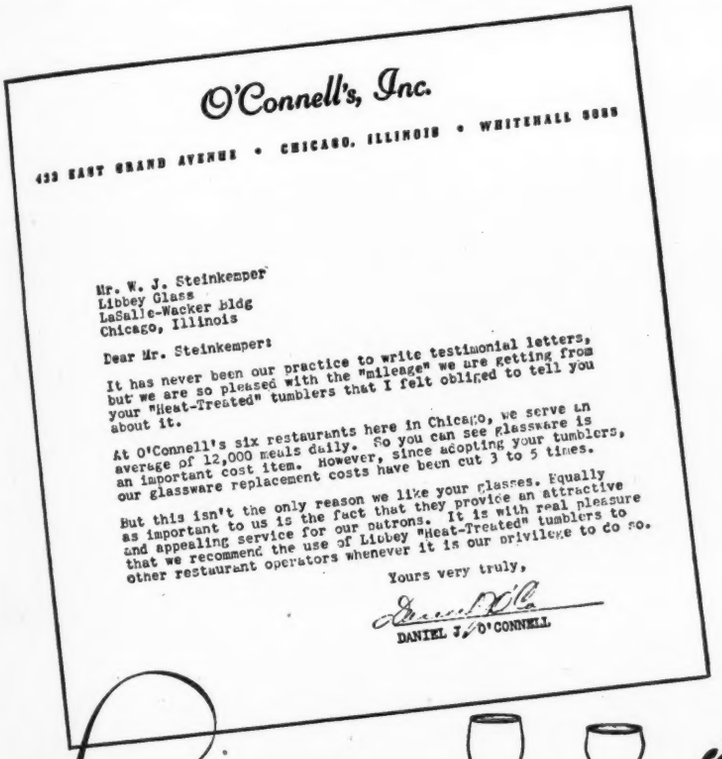

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which we work. To use them skillfully in these times requires real artistry.

For the therapeutic dietitian or the dietitian in a small private hospital, getting along with people includes patient contacts. The problem is not always solved simply by providing the right food. Often it is part of the dietitian's task to persuade the patient to accept it. In any case, the dietitian who visits her patients at mealtime gets a true picture of the hospital food service.

Can She Accept Criticism?

What about the dietitian's reaction to complaints? The ability to take criticism is part of the art of getting along with people. Too many of us react defensively to any criticism from whatever source and regardless of whether it is constructive or otherwise. Anyone who accomplishes anything is sure to be criticized. The dietitian who learns to use criticism, to sift from it that kernel of helpful truth that can usually be found and use it as a mirror to see her department's or her own faults has taken a long first step on the road to success.

Finally, I should like to use a homely phrase to describe the last of the three skills I think are basic for the art of dietetics—the art of "taking pains," or attention to detail if you wish to put it that way. Only a few "administrative" dietitians are purely administrators. Usually their function is also executive. Not only do they establish standards and make policies but it is part of their duty to see that those standards are adhered to and that the policies are carried out.

For the large majority of us dietetics is no swivel-chair job. For instance, any good dietitian is a "taster." Not only does she check the food in the kitchen but she follows her meals to the patient to see that she is actually achieving her goals.

Are the cold foods really as cold as they could be? Would a little crushed ice help the carrot strips? A restaurant would use it, why not a hospital?

Are the proper dishes being used or does the tray room maid serve cold salads on warm plates and warm food on cold plates?

While visiting a hospital not so long ago I saw pumpkin pie served in one unit in sauce dishes and in another unit on 9 inch platters. I ventured a remark about the difficulty of obtaining dishes and was told that they had been able to get all they needed! Painstaking care in correcting little faults, planning minor details and observing the little things are the prelude to deep and widespread food satisfaction. It is good for dietary employes to remember that "trifles make perfection but perfection is no trifle."

Art Has a Long Way to Go

Few of the complaints that one hears about hospital food have to do with dietary inadequacies. Most of them are that food is unappetizing or cold or unattractively served. The science of dietetics has developed rapidly in the last twenty years, but the art of dietetics is still in its infancy.

Food sense, skill in cookery, the "know how" that it takes to work with and use people and a willingness to use time and energy in perfecting minor details, these are essentials for the hospital food administrator.

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Menus for December 1945

Jacqueline Lefton
Edgewater Hospital
Chicago

1
Rhubarb
Omelet
•
Split Pea Soup
Baked Spareribs
Sauerkraut
Baked Squash
Tomato Aspic Salad
Crumb Cake
•
Rice Broth
Chicken Pot Pie
Hard Rolls
Apricot-Cream Cheese Salad
Oatmeal Cookies

2
Sliced Oranges
Coffee Cake, Plum Jelly
•
Consommé
Roast Beef
Parsley Buttered Potatoes
Cauliflower
Carrot-Raisin Salad
Danish Layer Cake
•
Cream of Mushroom Soup
Cold Meats
Hot Potato Salad
Tomato Wedges
Rye Rolls
Boston Cream Pie

3
Kadota Figs
Scrambled Eggs
•
Celery Stock Soup
Veal Supreme on Toast
Baked Potatoes
Winter Tomato Salad
Blackberry Cobbler
•
Philadelphia Cream Soup
Broiled Fish
Mashed Potatoes
Asparagus Tips
Orange Sandwich Salad
Lazy Daisy Cake

4
Sliced Bananas
Canadian Bacon
•
Tomato Bouillon
Baked Ham, Horseradish Sauce
Candied Sweet Potatoes
Head Lettuce, Thousand Island Dressing
Pecan Pie
•
Chicken-Rice Soup
Egg Soufflé, Mushrooms
Green Beans
Waldorf Salad
Tapioca Cream Pudding

5
Stewed Prunes
Soft Cooked Eggs
•
English Beef Broth
Calves' Liver
Baked Stuffed Potatoes
Buttered Beets
Salad Bowl
Malted Milk Cake
•
Cream of Carrot Soup
Pickled Tongue, Mustard Sauce
Escalloped Potatoes
Combination Fruit Salad
Spanish Cream

6
Tomato Juice
Poached Eggs on Toast
•
Vegetable Soup
Swedish Meat Balls
Baked Noodles
Broccoli
Celery Ring Salad
Lime Ice, Sugar Cake
•
Spun Egg Soup
Broiled Sweetbreads
Buttered Rutabagas
Race King Salad
Lattice Peach Pudding

7
Stewed Peaches
French Toast, Sirup
•
Vegetable Soup
Lobster and Mushrooms in Patty Shells
Browned Potatoes
Brussels Sprouts
Stuffed Green Pepper Salad
Devil's Food Cake
•
Consommé Bellevue
Deviled Eggs on Toast, Parsley Cream Sauce
Kidney Bean Salad
Fruit Cup, Ginger Snaps

8
Tangerines
Pancakes With Sirup
•
Cheese Soup With Rice
Old-Fashioned Chicken Dumplings
Broiled Tomatoes
Jellied Vegetable Salad
Apple Pie
•
Fruit Juice
Creamed Dried Beef on Toast
Sautéed Corn
Preserved Fruit Salad
Mocha Bavarian Cream

9
Sectioned Grapefruit
Pork Sausage, Hominy
•
French Onion Soup
Leg of Lamb, Mint Sauce
Hashed Brown Potatoes
Cauliflower in Cream
Minted Pears, Crusty Roll
Sherbet, Sugar Tarts
•
Purée Jackson Soup
Mock Chicken Legs
Corn in Pepper Cups
Jellied Cucumber Salad
Dixie Chocolate Cake

10
Orange Juice
Drop Eggs
•
Vermicelli Soup
Broiled Steaks
Mashed Potatoes
Harvard Beets
Relish Plate
Graham Cracker Pie
•
Pepper Pot Soup
Minced Ham Sandwich
Potato Chips
Asparagus Salad
Caramel Custard

11
Apricot Juice
Link Sausages
•
Cream of Potato Soup
Roast Duck, Stuffing
Mixed Vegetables
Cranberry Relish
Raspberry Parfait
•
Barley Broth
Golden Rod Eggs on Toast
Baked Potatoes
Stewed Tomatoes
Lettuce Salad, French Dressing
Brownies

12
Baked Apples
Scrambled Eggs
•
Creole Soup
Lamb Chops
Butter Ball Potatoes
Creamed Onions
Pineapple-Marshmallow Salad
Burnt Sugar Cake
•
Chicken Noodle Soup
Tuna Casserole
Brown Corn
Green Plum Salad
Doughnuts

13
Stewed Peaches
Poached Eggs on Toast
•
Italian Brown Soup
Veal Cutlets
Baked Wild Rice
Creamed Spinach
Cabbage and Apple Salad
Jelly Roll
•
Cream of Onion Soup
Grilled Ham With Minute Potatoes
Asparagus Tips
Molded Fruit Salad
Gingerbread With Cream Topping

14
Mixed Fruit Juice
Cinnamon Rolls
•
Consommé Julienne
Baked Fish, Tartare Sauce
Boiled Potatoes
Buttered Peas
Sliced Beet Salad
Brown Betty
•
Peanut Butter Soup
Escalloped Cabbage With Cheese and Tomatoes
Raw Carrot Sticks
Frozen Fruit Cup
Cookies

15
Kadota Figs
Baked Eggs
•
Philadelphia Pepper Pot
Stuffed Breast of Chicken, Sweet Potato Puffs
Corn Niblets
Shredded Lettuce, Grapefruit Salad
Banana Cake
•
Cream of Vegetable Soup
Manhattan Meat Roll
Mashed Potatoes
Breaded Eggplant
Tomato Salad
Apricot Whip

16
Baked Stuffed Apple
French Toast, Sirup
•
Mock Turtle Soup
Roast Pork Loin, Hot Cranberry Sauce
Lyonnaise Potatoes
Buttered Broccoli
Brown-Eyed Susan Salad
White House Pecan Pie
•
Canadian Cream Soup
Cold Plate: Tongue, Danish Sauce, Spiced Peach
Duchess Potatoes
Sliced Turnips
Victoria Salad
Orange Cake

17
Stewed Prunes
Wheatcakes, Honey
•
Consommé
Veal Scallopini
Parisian Potatoes
Brussels Sprouts
Carolina Salad, Chantilly Mayonnaise
Walnut Cake
•
Cream of Giblet and Rice Soup
Poached Eggs Benedict
Baked Squash
Cheese Ball Salad
Apple Dumplings

18
Loganberry Juice
Soft Cooked Eggs
•
Oxtail Soup
Broiled Brisket of Beef, Albert Sauce
Surprise Potatoes
Braised Celery
Peach Stone Salad
Napoleon Slices
•
Bouillon Jardiniere
Cheese Fondue, Mexican Tomato Sauce
Cottage Fried Potatoes
Mixed Vegetable Salad
Rebecca Pudding

19
Sliced Bananas
Scrambled Eggs With Minced Ham
•
Purée Mongol Soup
London Grill Lamb Chops
Delmonico Potatoes
Grilled Tomatoes
Coleslaw
Lemon Chiffon Pie
•
Golden Bouillon
Creamed Crabmeat and Shrimps
Saratoga Chips
Spinach With H. C. Eggs
Fan Fruit Salad
Chocolate Sponge Roll

20
Broiled Grapefruit
Buckwheat Cakes, Sausages
•
Old-Fashioned Vegetable Soup
Flanked Steak Baltimore
Oven-Browned Potatoes
Cardinal Pear Salad
Caramel Cream Puffs
•
Cream of Beet Malta
Sweetbreads in Casserole, Tomato and Vegetable Gravy
Baked Cheese Potatoes
Paradise Salad
Peppermint Ice Cream

21
Tomato Juice
Omelet, Cornmeal Muffins
•
Corn Chowder
Halibut Mornay
Buttered Green Beans
Waldorf Salad
Icebox Cake
•
Chef's Mushroom Soup
Vegetable Chop Suey
Boiled Rice
American Cheese, Tomato, Chopped Pickle Salad
Graham Nut Slice

22
Stewed Pears
French Omelet
•
Mulligatawny Soup
Broiled Pork Tenderloin, Cream Gravy
Candied Sweet Potatoes
Buttered Cauliflower
Fruited Gelatin Salad
Sugar Plum Cake
•
Hot Tomato Juice
Chicken Croquettes, Mushroom Sauce
Baked Stuffed Potatoes
Broccoli
Royal Tomato Salad
Apple Pie and Cheese

23
Orange Juice
Egg Pancakes
•
Chicken Broth
Roast Duck
Apple and Prune Dressing
Wild Rice
Baked Squash
Marinated Vegetable Salad
Fruit Cake
•
Beef Gumbo Soup
Spaghetti and Liver Casserole
Spinach With Egg Garnish
Relish Plate
Walnut Pudding

24
Prune Juice
Country Sausage
•
Lentil Soup
Baked Veal Chops
Fried Mushrooms
Parsley Buttered Potatoes
Creamed Spinach
Lettuce Hearts, Russian Dressing
Fruit Tarts
•
Consommé Theodora
Shirred Eggs on Duchess Potatoes
Asparagus Tips
Candied Apple Salad
Bread Pudding

25
Stuffed Apples
Bacon Roll, Egg Drops
•
Almond Soup
Roast Turkey
Oyster Dressing
Spiced Crabapples
Snow Ball Potatoes
Minted Peas
Jellied Cranberry, Apple and Orange Peel Salad
Hot Plum Pudding, Brandy Sauce
•
Golden Bouillon
Ham, Cinnamon Pear and Vegetable Salad Plate
Pumpkin Pie With Whip Cream

26
Loganberry Juice
Scrambled Eggs
•
Purée Tomato Soup
Calves' Liver With Onion Sauce
Country Browned Potatoes
Buttered Lima Beans
Jellied Gingerale Salad
Date Pudding
•
Alphabet Soup
Tuna Supreme on Toast
Baked Noodles
Harvard Beets
Toasted Coconut and Pear Salad
Angel Cubes, Orange Sauce

27
Sliced Bananas and Oranges
Bacon and Eggs
•
Barley and Bean Soup
Rolled Lamb Loin Roast, Apricot Sauce
Shoestring Potatoes
Rice, Cheese and Onion Salad
Mint Sherbet, Hermits
•
Tomato-Kraut Juice
Lobster Thermidor
Potato Balls
Stewed Okra
Cabbage, Carrot and Pepper Salad
Deep Dish Pie

28
Stewed Pears
Pancakes and Sausage
•
Vegetable Chowder
Planked Halibut
Sweet and Sour Carrots
Black-Eyed Susan Salad
Butterscotch Pie
•
Beet Soup
Macaroni and Chipped Beef
Buttered Asparagus
Winter Salad, Italian Dressing
Deep Chocolate Cake

29
Apple Juice
Sweet Rolls, Grape Jelly
•
•
Sweet Potato Soup
Potted Beef, Dumplings
Cabbage au Gratin
Tomato Surprise Salad
Mock Cheese Torte
•
•
Onion Soup
Chicken Creole With Rice
Corn O'Brien
Mixed Pickle Salad
Marble Cake

30
Grapefruit Halves
Poached Eggs
•
Cream of Tomato Soup
Baked Ham, Raisin Sauce
Paprika Buttered Potatoes
Creamed Turnips
Banana-Nut Salad
Cream Fudge Cake
•
V-8 Cocktail
Stuffed Green Peppers
Mixed Vegetable and Rice Mold
Pickled Beet and Onion Salad
Peach Icebox Cake

31
Papaya Juice, Canadian Bacon • Split Pea Soup, Swiss Steak, Creole Potatoes, Rutabagas, Raw Spinach Salad, Mustard Dressing, Hot Cherry Pie • Scotch Broth, Baked Veal Pie With Potato Top, Stewed Tomatoes, Mixed Vegetable Salad, Fruit Squares

Ready-to-eat or cooked cereals are offered on all breakfast menus.

Six Steps to Good Maintenance

SISTER MARY BENIGNUS LEAHY, R.S.M.
Administrator, Mercy Hospital, Hamilton, Ohio

THE physical plant and equipment, together with their maintenance and repair, are of vital importance in any hospital, not only from the standpoint of satisfactory service but also from a financial point of view.

Regardless of what type of physical plant and equipment the hospital may have, the following points, if observed, will aid toward a smooth and satisfactory maintenance and repair program.

1. The plant should be staffed with properly trained personnel, having a chief engineer with leadership and ability.
2. The hospital administrator should take an active interest in the entire physical plant.
3. The scope of responsibility of the chief engineer and his men should be definitely established and followed.
4. There should be teamwork between the personnel of the other departments of the hospital and that of the maintenance department.
5. Constant study should be made of possible improvements in methods; special attention should be given to new equipment and to safety controls.
6. A workable and practical system of requesting repairs and requirements should be installed.

Constant Checking Is Necessary

The chief engineer should be loyal and cooperative. To be successful with his men he must be a leader, capable of working harmoniously with people and able to train workers in trouble-finding so that breakdowns can be foreseen and prevented. Often a few drops of lubricating oil will prevent a shutdown of a mechanical stoker, a vital engine or even a refrigeration plant. Continual checking and inspection of all machinery are necessary for proper maintenance.

A hospital that has a worth-while maintenance crew should make every effort to retain it. Changes mean a loss. It takes time to train a man to handle complicated hospital equipment.

The hospital administrator should visit the plant frequently and be familiar with the functions of the various workers and even with the machines and pieces of equipment. It is quite an incentive to any man to do better work if he knows that someone in authority notices and commends his efforts. This is true especially in keeping workshops and boiler room surroundings clean and orderly, machines shining and bright and running smoothly.

The boiler plant, including refrigeration and all mechanical equipment, should be under the supervision and control of the chief engineer and his men. It is wise to consult the engineer prior to purchasing and installing mechanical or electrical equipment, since he can offer valuable information as to the working of this equipment.

This policy will pay many times over if only in the case of a simple floor or bedside lamp. It is understood, however, that all or any equipment purchased or installed must meet the requirements of the National Board of Fire Underwriters.

If the boiler department crew is working harmoniously with other department personnel in the hospital, a better understanding of operation of mechanical equipment will exist.

If the hospital is a member of the local unit of the National Safety Council, the informative material given out by this organization will be helpful. Both reading the literature and attendance by the engineers and men in the plant at safety council meetings make the workers more conscious of accidents and hazards.

When possible it is advisable to have a branch or safety unit organized within the hospital organization itself, the members of this unit to be made up of key personnel, such as supervisors and department heads. This activity could function through the personnel office. When accidents are prevented maintenance requirements are automatically lowered. Another name for maintenance service might be "safety measures."

Hospital magazines should be routed to the chief engineer. He will derive much value from the plant operation and maintenance section. In addition, he will learn a great deal from other articles covering all phases of the hospital.

Survey the Physical Plant

From time to time it would be healthy and beneficial for a hospital administrator to have a consultant come in and give an honest criticism on the maintenance program or, as is done in industry, conduct an efficiency survey in the physical plant, laundry, kitchens and any other departments in the hospital where such a survey is deemed worth while. Untold value would result, perhaps through the relinquishing of less efficient methods and the adoption of more economical programs.

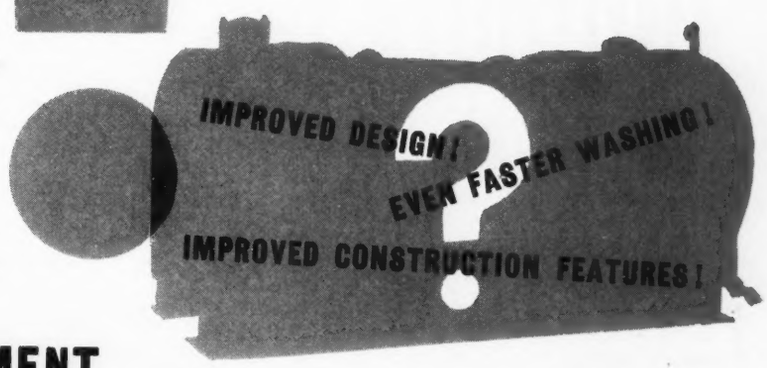
Some system in reporting needed repairs should exist, preferably written on a special form, dated and signed by a responsible department head. Urgent service should be marked "Emergency." Notices should be placed in a specified box for the maintenance man. Thoughtless rush telephone calls should be avoided if possible since they are time-consuming and interfere with planned schedules of the men. Often a repair can be made at a convenient time, thus preventing a complete breakdown and interruption of vital service.

A light, pleasant and airy workshop is desirable and will be found conducive to a good repair program.

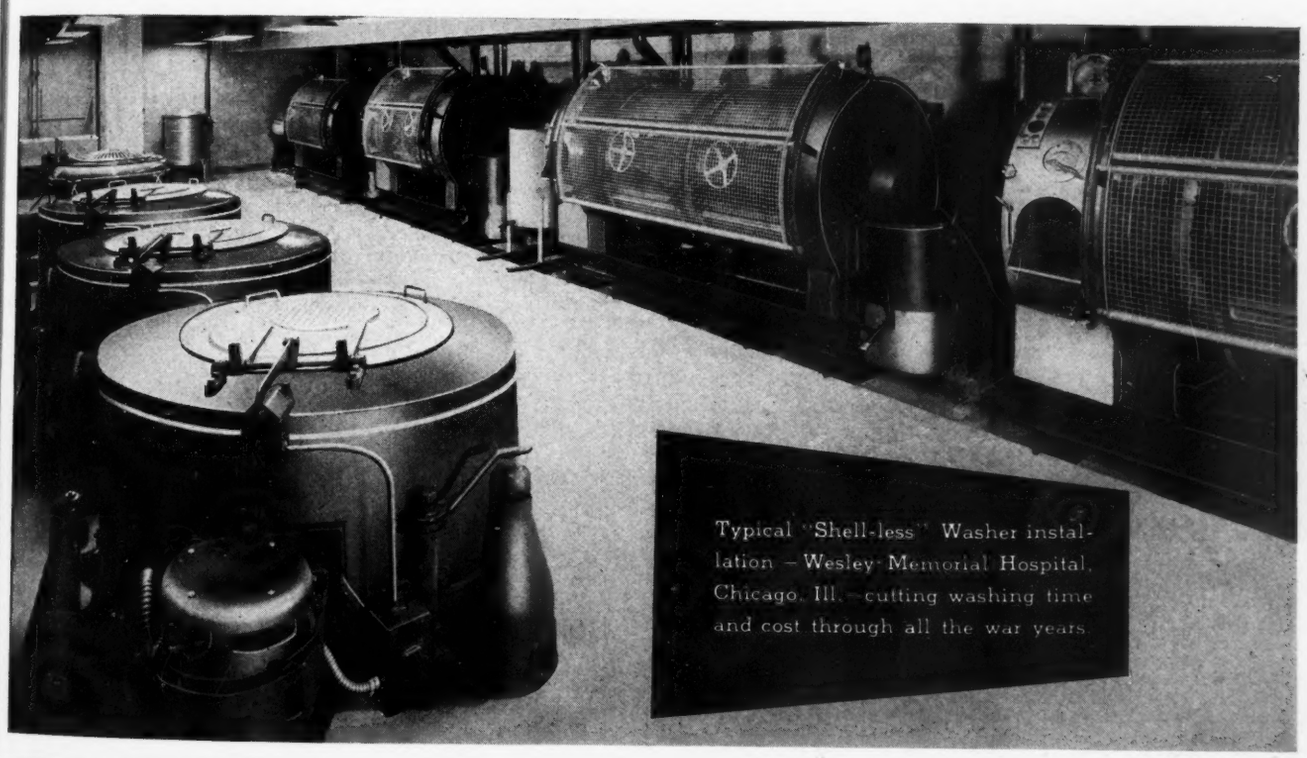
THE ANSWER TO THE QUESTION THAT MANY HOSPITAL SUPERINTENDENTS ARE ASKING:

YES! HOFFMAN "SHELL-LESS" WASHERS WILL BE BACK SOON

Remember the Hoffman "Shell-less" washer? —the sensational washer that does the work of two ordinary washers of the same size?—the washer that gives you non-stop soil removal from begining to end of the washing cycle?—the washer that lengthens the life of linen? This is advance notice that—as soon as reconversion difficulties can be overcome—the Hoffman "Shell-less" washer will be back—improved in design and construction, and offering even greater advantages than before!



WATCH FOR ANNOUNCEMENT



Typical "Shell-less" Washer installation – Wesley Memorial Hospital, Chicago, Ill. – cutting washing time and cost through all the war years.

U. S. HOFFMAN MACHINERY CORPORATION
107 Fourth Ave., New York 3, N.Y.

COMPLETE LAUNDRY EQUIPMENT SERVICE FOR THE INSTITUTION

In conclusion, it may be said that with regard to maintenance and repair of equipment the human element plays a most important part and nothing can take the place of careful operation and handling. Occasional talks given by the men making the repairs to the members of the housekeeping department, to the dietitians and aides and to the student and graduate nurses in the hospital may help reduce breakdowns caused by carelessness or accidents and also create a wholesome interest and understanding.

Written instructions as to the proper use of equipment should be available at all times so that the inexperienced employe can obtain simple information.

The members of the engineering and maintenance departments should receive honest credit and remuneration for their valuable contribution to the institution's program and upkeep.

If the same highly personal and interested care that is given to one's own watch or fountain pen is given by the worker to every piece of equipment used in the hospital, there will be fewer repair calls for the overworked hospital maintenance man.

BETTER PLANT PRACTICES

Watch Fire Extinguishers

Think twice before determining locations for portable fire extinguishers, the Safety Research Institute of New York warns. Extinguishers must be readily available and be placed so that access to them is not likely to be cut off by fire.

For general protection, one large or two small extinguishers should be within 50 feet from any point in the area. When used to safeguard a specific fire area, extinguishers should be mounted near it but not on or too close to the hazard.

In a relatively small room, extinguishers should be mounted just inside or outside the doorways where they are accessible yet do not interfere with a safe line of retreat in emergencies. They may be mounted on columns or on walls with hangers, brackets or shelves as supports.

The tops of easily handled units should be not more than 5 feet from the floor. Tops of heavy units should not be more than 3½ feet from the floor.

Finally, extinguishers should be placed where they can be plainly seen or else their locations should be marked with conspicuous signs. They should be checked frequently and obstructions should be removed without delay.

Since many types of hand extinguishers require annual recharging even though they have not been used, all extinguishers should be inspected at least once a year to make sure nozzles are not clogged.

On the Subject of Floors

Thomas A. Hawkins of Wayne University, in his recent publication, "What Every Custodian Should Know," lists eight subjects on which the housekeeper should post herself. These are: (1) the important ingredients that go into the manufacture of the commonly used floors; (2) how the various floors are made; (3) the characteristics of floors—their good qualities, bad qualities and wearing qualities; (4) the best type of floors for various parts of the building; (5) the type of cleaners and treatments that are injurious to floors; (6) cleaners and treatments that will not injure floors; (7) the ingredients used in well-known cleaners and treatments, and (8) the most economical maintenance methods.

HOUSEKEEPING

Conducted by Alta M. La Belle

These Talented Housekeepers

If the executive housekeeper of today is nothing else, she is versatile. She has to be. Just how varied are the talents of the members of this rising profession was brought home to us by a letter from one of them, modestly recounting a little extracurricular activity that she had undertaken for the entertainment of the patients in her hospital, an eastern institution for psychiatric patients.

But let's let the lady in question, Mrs. Florence DuBois Mooers, tell her own story:

". . . I prepared a talk—a running commentary really—on the poetry and life of Edgar Allan Poe and gave it through the occupational therapy department for the entertainment of the patients. I illustrated it with several of Poe's poems set to music, the songs being sung by two patients with excellent voices. . . . One of them sang two settings of Poe's 'Helen' most beautifully. I read the poems, from memory, first.

"It was such a joy to watch the interested faces of the patients for I have seen them register enormous boredom at times. I asked them to judge how well, in their opinion, the composer had caught the essence of the poem. (Did you know that more composers have tried their skill at composing for Poe than for any other poet? More than 252 compositions so far.)"

That proves the point about versatility, surely. There is a lot more to housekeeping than just pushing the maid who pushes the mop!

It would be interesting to know what other housekeepers do for intellectual exercise in their spare time. Let's hear from you.

Handbook for Housekeepers

A valuable addition to the executive housekeeper's library is the "Hospital Housekeeper's Handbook," prepared by Stella E. Heinze, executive housekeeper of North Carolina Baptist Hospital, Winston-Salem, N. C., in cooperation with the department of vocational education of the Winston-Salem city schools.

After a general discussion of the duties and qualifications of the executive housekeeper and the various members of the housekeeping staff, Miss Heinze divides the book into four main sections.

The first chapters contain outlines of lectures that can be adapted for use as training material for housekeeping employes and also include a sample certificate to be presented to the employe on completion of the course.

Section 2, headed "The Employe," contains samples of employes' work schedules; an estimate of standards for production on certain types of jobs; rating sheets for evaluation of personal appearance and also of the work done, and a suggested procedure for inducting the new employe into his job.

The third section includes cost charts, budget estimates, job analysis sheets and organization charts.

The handbook closes with a section of general information, including methods of stain removal, insect control and a miscellany of helpful hints on problems that often face the harassed housekeeper.

Although the work schedules, rating sheets and cost and budget analyses were worked out for a particular hospital they can well be adapted to the needs of other institutions of all types.

Nurse them along—

THREE RULES FOR LASTING LINENS

THE RIGHT TOWEL for the purpose. A hand towel at the right place saves unnecessary use of bath towels . . . costs less to launder, too. Don't use towels on sharp instruments. Wise use of cloths and cleansing tissues spares towels many tough jobs.

ROTATE TOWELS AND SHEETS to give 'em all a rest. From laundry to top of pile, from bottom of pile to use . . . that's the share-the-wear program that lengthens towel and sheet service.

FIRST AID to towels and sheets pays dividends. Prompt mending of tears, ravels and breaks adds months of service. And watch out for rough or splintered shelves and hampers. It's easier to fix them than to replace linens. Cannon Mills, Inc., 70 Worth Street, New York City 13.

NEWS IN REVIEW

A.H.A. Rejects Proposal to Limit Approval of Blue Cross Plans

A proposal to limit A.H.A. approval to Blue Cross plans with at least 25,000 members and an enrollment aggregating 1 per cent of the population for each year of plan operation was rejected by the board of trustees and House of Delegates at their Chicago meetings. Postponing consideration of these recommendations, which were included in the official report of the Blue Cross Commission, until the 1946 meeting, trustees and delegates left the approval program unchanged except for a statement urging full compliance with the existing approval standard having to do with adequate general and contingency reserves.

Although prior action by the board of trustees pointed the way to this result before the issue was presented to the house, several delegates presented spirited speeches opposing the commission's recommendation as introduced by chairman John Mannix and supported in a special report by Dr. Lewis E. Jarrett, a member of the approval committee.

Reasoning that the establishment of minimum enrollment requirements would spur lagging plans to more vigorous promotion and generally strengthen the national unity of Blue Cross, the commission members asked that the 25,000 minimum standard be applied to every plan that had been approved for at least three years, and that all plans be required to average 1 per cent of the population enrolled per year of operation in order to maintain approved status.

"The majority of plans now greatly exceed these minimal requirements," Mannix said. "No lesser requirements would appear reasonable if any quantitative measure is attempted."

It was quickly apparent that many of the delegates were opposed to any such measurement being applied, either because it might be a hardship for plans whose enrollment problems were especially difficult, or because it was felt this kind of disciplinary action would be less effective in producing the desired result—increased enrollment—than other possible steps.

Objecting for territorial reasons was Texas delegate Robert Jolly, who enlivened the discussion by pointing out the Blue Cross enrollment problems inherent in the distance from Houston to Amarillo, mile by mile, and suggested that instead of applying minimums the commission should lend expert assistance to plans with enrollment headaches. Monsignor Griffin approved the principle of positive commission action looking toward increasing membership in all plans but also felt that this should be achieved through promotional aids rather than withdrawal of approval.

Objection to the absolute minimum of 25,000 was voiced by Ritz Heerman, trustee from California, who envisioned an ideal Blue Cross plan in a community where the entire population did not reach that total. As the delegates voted to pass over these recommendations until next year, there were many who felt that the issue of minimum enrollment as an approval requisite was closed for considerably more than a year.

A.H.A. Takes Steps Toward Pension Plan

(*Continued From Page* 94)

studied the problem and recommended adoption of the plan felt that this would put the cost out of reach of most hospital employes. Under the plan, however, an employe who terminates his employment before age 65 will receive an amount equal to the total of his own contributions to the plan, plus 2 per cent interest compounded annually, and the same amount will be paid to the beneficiary of an employe who dies.

Eligibility to participate in the plan will be restricted to employes 25 years of age and over who have been employed at least a year in the hospital. These restrictions are necessary, it was explained, to eliminate turnover and keep down the cost of operating the plan. Every effort will be made, Husch said, to make it possible for an employe who changes from one hospital to another to do so without losing earned benefits.

The plan will operate in conjunction with a similar pension trust recently launched by the National Health and Welfare Retirement Association for employes of all social agencies. Several hospitals have already joined the N.H.W.R.A. plan, it developed, but the A.H.A. committee felt that a separate corporation and a somewhat different schedule of benefits were desirable for the hospital trust. However, the trusts will be administered jointly.

The action by the House of Delegates authorized the board of trustees to appoint a committee with full power to act for the association in organizing the corporation. A detailed announcement of progress should be forthcoming from the association before long, it was indicated, and as soon as possible interested hospitals will be informed of the procedure to be followed in applying for participation privileges.

Propose Campaign for Memorial Center Honoring Nurses

By EVA ADAMS CROSS

WASHINGTON, D. C.—An organization has been formed to launch a nation-wide campaign for the raising of $2,000,000 to be used in the construction and endowment of a Nurses' National Memorial, Mrs. Norman T. Kirk, wife of the Army's surgeon general, has announced.

The memorial, a tribute to the heroic nurses of World War II, will take the form of a social center and temporary residence for medical women of the armed forces, Mrs. Kirk explained. The center will have sleeping accommodations for at least 300 women, a library, assembly rooms, living rooms, dining room facilities and lounges.

More than 80,000 women will be eligible for the privileges of this center whose facilities may be enjoyed at low cost. The memorial has been incorporated and legislation will be introduced in Congress for a charter. Among the sponsors are Mrs. Harry S. Truman, Major General Kirk, V/A Ross T. McIntire, as well as wives of distinguished Army and Navy officers.

Health Program Proposed

WASHINGTON, D. C.—Referred to a Senate committee for consideration was the House-approved bill to provide for health programs for government employes. Such health services would be established only upon recommendation of the Civil Service Commission after consultation with the U. S. Public Health Service. They would be limited to (1) treatments on the job of minor illnesses and minor dental conditions, except in cases of emergency or of injury sustained while in the performance of the employe's duty; (2) preemployment and other examinations; (3) referral of employes to private physicians and dentists, and (4) education and preventive programs relating to health.

Replace Medical Personnel

WASHINGTON, D. C.—A joint resolution introduced in the Senate would provide for the replacement of medical personnel commissioned from civilian life with persons trained under the Army Specialized Training Program. The resolution set forth that in order to accelerate the return to civilian life of doctors, dentists and veterinarians who have served in the Army of the United States during the war, the services of personnel trained under the A.S.T.P. program shall be utilized to the greatest extent practicable to replace such doctors, dentists and veterinarians.

Paid Advertising Urged by Reginald Cahalane to Tell Hospital Story

A radical departure in hospital public relations was proposed at the A.H.A. house of delegates meeting by R. F. Cahalane, who urged in a supplement to his annual report as chairman of the council on public relations that hospitals use "controlled mass education," or paid advertising, to tell the public about their work and their needs. Once it was made clear that such methods were not intended for competitive use in advertising the services offered by individual hospitals, a motion approving the proposal as an aid to "interpreting hospitals to the public" was passed by the house without dissent, and without much discussion.

Cahalane cited the results obtained through advertising for Massachusetts Blue Cross to support his contention that this is the best way to present the hospital story. Over a period of ten months, he said, total Blue Cross membership was increased 127 per cent by a series of newspaper display ads featuring the advantages of membership. A number of different displays were used in test runs, he explained, and the results were carefully measured. Interestingly, the display that proved to be the most effective producer of direct inquiries was one that listed all the member hospitals in the plan, while those showing pictures of pretty girls in hospital beds were comparatively useless.

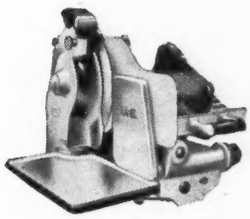
In response to a question, Cahalane stated that the state medical society, which operates a medical service plan in cooperation with Massachusetts Blue Cross, had raised no objection on ethical grounds to the use of advertising. In fact, he reported, the society specifically approved the program and it was planned shortly to advertise the medical service plan as well. The advertising budget for Blue Cross was set at 1 per cent of membership fees, and the campaign was conducted through the New York office of J. Walter Thompson, advertising agency.

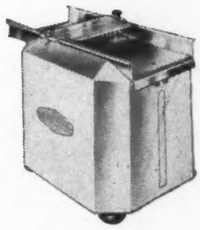
At the meeting of Blue Cross executives in New York a few days earlier, Cahalane presented a detailed study of the Massachusetts experience, together with sample ads and a recommended followup procedure. He urged immediate adoption of the paid advertising method for all Blue Cross plans as the only means of promoting membership increases at a rate that will forestall government entry into the health insurance picture. Roy Larsen, publisher of *Time* magazine, also asked Blue Cross leaders to consider this method seriously. "Your cup isn't one seventh full," Larsen said, referring to the fact that one seventh of the population is now enrolled in Blue Cross. "It's six sevenths empty—and the only way to fill it is with advertising." Besides Massachusetts, other Blue Cross plans that have used paid advertising include those with headquarters at Portland, Me., Harrisburg, Pa., Albany, N. Y., and New York City, where advertising was used in connection with an individual enrollment project.

Other subjects covered in the council on public relations report at the Chicago meeting were National Hospital Day, the "Help Your Hospital" campaign and the Quill and Scroll project to implement hospital public relations through high school journalism students.

Legislation for Research

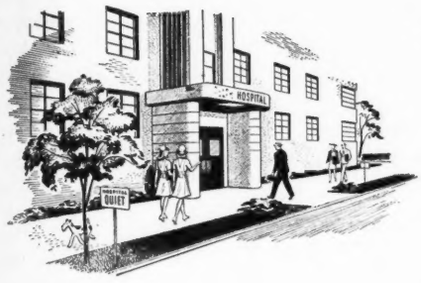
WASHINGTON, D. C.—A new bill to establish a National Research Foundation has been introduced in the House. The agency would be headed by a board of nine members appointed by the President. The bill is similar to the Magnuson-Mills-Randolph bills. Joint hearings on several scientific research bills were concluded November 2 with much of the emphasis placed on the Magnuson and Kilgore proposals. A compromise bill will probably be worked out as a result of the lengthy discussions of the various proposals.

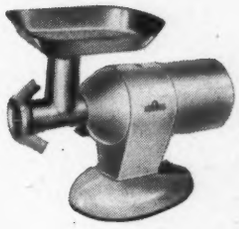




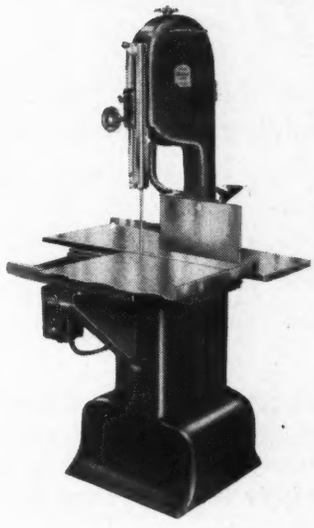
Modernized

OUTSIDE AND *IN!*

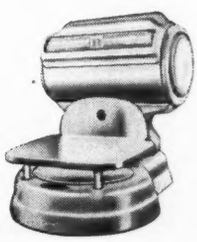




● Modernization means more than an attractive building. It means the best of service and equipment too. And since it's natural to want the most up-to-date machines in your kitchen, you will turn to the famous U. S. line of Quality Food Machines. For this equipment is full of benefits for every hospital—in time and labor-saving service. These machines are available for your urgent replacement or expansion needs. Call or write a U. S. representative.



- U. S. SLICERS
- U. S. TENDERIZERS
- ENTERPRISE CHOPPERS
- ENTERPRISE COFFEE MILLS
- WELLS QUIKUT MEAT SAWS
- STANDARD COMPUTING SCALES



U S SLICERS

Quality Food Machines

U. S. SLICING MACHINE COMPANY

LA PORTE, INDIANA

Bugbee Reports on Progress of Bill to Aid Hospitals

Significant federal aid for a program of hospital expansion and construction providing service where it is most needed will become an actuality, possibly during the next year, in the opinion of the A.H.A. officials who have sponsored and closely followed developments in connection with S. 191, the hospital construction and survey bill. Discussion of the pending legislation had an important place on the agenda at the House of Delegates meeting.

S. 191 was recently returned to the Senate Committee on Education and Labor with a favorable report from a special subcommittee after exhaustive hearings in which A.H.A. officers took an important part. It is expected that the bill will be reported out of committee and considered by the Senate during the present session of Congress.

Familiar now to most hospital people, the main features of the bill provide for grants-in-aid to states for detailed surveys of hospital service and construction of public and nonprofit hospitals, health centers and clinics to meet the needs revealed in the surveys. The step by step story of how this legislation was written, rewritten and revised according to pressures brought to bear by various interested groups during the subcommittee hearings was related by George Bugbee, A.H.A. executive director, who assured delegates that the bill as presently constituted was satisfactory to hospitals.

The bill provides that administration of the survey and building programs will be under the general supervision of the United States Public Health Service, aided by an advisory council representing the interested professions and the public. However, Bugbee said, the states themselves will keep responsibility for setting hospital standards to govern the intra-state allocation of funds. This means that a hospital licensing program will be developed in every state, he added. Allocation of federal aid funds among the various states will be made according to a formula based on the need for hospital construction and the financial condition of the states. The federal appropriation for the first year of operation is set in the bill at $750,000,000.

"This bill represents the first really aggressive action on the part of the A.H.A. with respect to federal legislation," John N. Hatfield, chairman of the council on government relations, stated in his annual report. The favorable outlook for hospital legislation was summed up by President Smelzer, who took an active part in the hearings: "Congress is responsive to your needs," he told the delegates.

VERIFIED to End Odor Problems in These Areas

BY AN INDEPENDENT SURVEY OF HOSPITAL PRACTICE

airkem

TRADE MARK REG. U. S. PATENT OFF.

CHLOROPHYLL AIR FRESHENER

Just check this list of places, where hospitals report using **airkem** Chlorophyll Air Freshener, against your areas of use. You may discover a number of important *new* uses for **airkem** in freshening indoor air, and ending odor problems.

airkem has adapted one of nature's most effective agents for freshening air in woods and fields — chlorophyll — and put it to work freshening indoor air. It is the only air freshener for institutional and professional application containing chlorophyll — activated for indoor use.

An ever-increasing number of hospitals, all over the country, are using **airkem** to end odors and create a fresh-air effect in all departments. If you do not already use **airkem**, a trial on some particularly annoying odor problem will bring you a brand-new experience in odor control. The easy-to-use wick bottle holds a pint, and costs only $1.59 in continental United States. **airkem** is also available in the economical gallon size for refilling wick bottles. Try it. W. H. WHEELER, INC., 234 East 46th Street, New York 17, N. Y.

WHERE DO YOU USE AIRKEM?

An independent research organization asked hundreds of hospital users of airkem this question. Their replies are tabulated on this chart.

PERCENTAGE OF AIRKEM USERS WHO REPORTED USE IN EACH AREA

- 94.2% USED AIRKEM IN WARDS
- 55.8% IN LAVATORIES
- 36.0% IN UTILITY ROOMS
- 22.1% IN OPERATING ROOMS
- 19.7% IN EMERGENCY ROOMS
- 17.4% IN PATIENTS' ROOMS
- 15.1% IN KITCHENS
- 56.2% IN PLACES SUCH AS:

WAITING ROOMS
STORAGE ROOMS
NURSERY SUPPLY ROOMS
AUTOPSY ROOMS
OFFICES
HALLS
CAST ROOMS
SMOKING ROOMS
LABORATORIES
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Harmony Prevails at A.H.A. Sessions

(*Continued From Page* 93)

E. Jarrett, a member of the commission's committee on approval. Actually, it was a lost cause by the time it reached the floor for discussion, because the Board of Trustees, meeting a day earlier, had already recommended to the house that consideration of the proposal be postponed until the 1946 meeting. This was done.

The president's dinner on the opening night turned out to be one of the liveliest meetings of the week when Lt. Col. Harry Brown, acting director of hospital service for the Veterans Administration, appeared as a substitute speaker for Maj. Gen. Paul R. Hawley, V. A. surgeon general.

Instead of making a formal address, Colonel Brown brought the group General Hawley's and his own assurances that every veterans' hospital would become a member institution of A.H.A. and that community hospitals would be used to the fullest extent possible in caring for veterans. Then he asked for, and got, questions on subjects ranging from the philosophy of government care of veterans to formulas for figuring hospital costs. The discussion left most of his hearers hopeful that a new era in veterans' hospital care is beginning.

Stimulating also was the talk presented by Lucile Petry, director of the U. S. Cadet Nurse Corps, who declared that nursing service must be provided by graduate nurses and auxiliary aides, not by students being paid in the cheap currency of "education." Reviewing cadet nurse corps experience, Miss Petry said it had proved that senior students were capable of assuming "internship" responsibilities, that recruitment effort plus scholarship aid would attract large numbers of well-qualified girls into nursing, and that cooperation of hospitals and colleges in nursing education was practical and desirable.

Officers elected by the delegates included, in addition to Mr. Hayes, first vice president, F. Stanley Howe, Orange Memorial Hospital, Orange, N. J.; second vice president, Sister St. John of the Cross, St. Mary's Hospital, Astoria, Ore.; third vice president, H. A. Coppinger, Winnipeg General Hospital, Winnipeg, Man., and treasurer, Dr. Harley A. Haynes, Ann Arbor, Mich.

Rev. John Barrett, director of Catholic hospitals for the archdiocese of Chicago, was elected to the board of trustees to replace Rt. Rev. Msgr. Maurice F. Griffin of Cleveland, who retired from the board after many years of service. Also named as trustees were Lawrence Payne, Baylor University Hospital, Dallas, Tex.; Dr. Robert H. Bishop, University Hospitals, Cleveland, and Dr. Charles F. Wilinsky of Boston's Beth Israel Hospital, who was reelected.

Elected delegates at large were past president Frank J. Walter, Good Samaritan Hospital, Portland, Ore.; Frank R. Bradley, Barnes Hospital, St. Louis; Winifred Culbertson, Children's Convalescent Home, Cincinnati, and Rt. Rev. Msgr. John J. Healy, director of Catholic hospitals, of the diocese of Little Rock, Ark.

The association's award of merit was presented posthumously to Asa S. Bacon, for many years superintendent of Chicago Presbyterian Hospital and A.H.A. treasurer, who died in October.

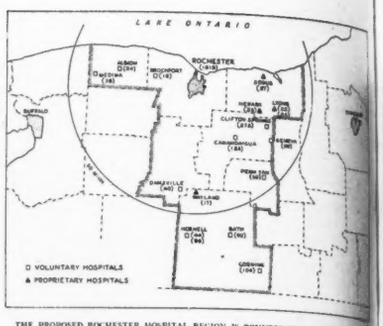
Train Army Medical Officers

WASHINGTON, D. C.—One hundred Regular Army officers have been assigned to Army general hospitals and medical installations as part of the Army's new plan to give professional training to officers of the Regular Army Medical Department, the Surgeon General's office has announced. Under this policy, such officers will be assured a professional career and aid in obtaining board certification for medical specialties from civilian specialty boards.

Commonwealth Fund Aids Cooperative Program in Rochester Hospitals

Fifteen hospitals in the Rochester, N. Y., area will participate in an experimental program looking toward cooperative organization of hospital and medical care and medical education on a regional basis, it was announced in October by executives of the Commonwealth Fund, which is underwriting the program with grants expected to reach a total of $1,375,000 over a period of five years.

Objective of the program, according to Henry J. Southmayd, director of the fund's division of rural hospitals, is "to determine whether a better distribution of better medical care can be achieved through concerted voluntary action by hospitals through representative organization on a regional scale." The Rochester area was chosen from among 20 medical teaching centers considered because, fund officials said, "both the machinery and the will to cooperate effectively are already present in the form of the actively functioning Rochester Hospital Council, the successful Blue Cross plan and a well-established council of social agencies."



THE PROPOSED ROCHESTER HOSPITAL REGION IS BOUNDED BY THE [illegible] (FIGURES IN PARENTHESES INDICATE BED CAPACITY OF HOSPITALS WITHIN THE [illegible]

Grants-in-aid totaling $200,000 a year will be made to member hospitals in smaller communities of the area, which embraces seven counties; this amount will be spent for building programs and the purchase of new equipment. In addition, $75,000 a year is to be allocated for administration and educational programs. Participating hospitals include the Bath Memorial, Bath; Bethesda and St. James Mercy, Hornell; Brockport Central, Brockport; Dansville General, Dansville; Clifton Springs Sanitarium, Clifton Springs; Thompson Memorial, Canandaigua; Geneva General, Geneva; Soldiers and Sailors Memorial, Penn Yan, and the Genesee, Highland, Park Avenue, General, St. Mary's and Strong Memorial hospitals in Rochester.

Rotation of interns and residents among the hospitals and organization of a continuous postgraduate education program for physicians, including clinical conferences and short refresher courses, are important educational features of the proposed plan, which also includes cooperative training of nurses, laboratory and x-ray technicians, dietitians, medical records librarians, admitting clerks and nonprofessional employes in other departments. Joint consulting services in radiology, pathology, anesthesia and hospital administration are provided, and operating economies are expected to result from cooperative purchasing.

The Commonwealth Fund laid down only the broad objectives sought through regional development; details of the plan have been worked out by a special committee of the Rochester Hospital Council, consisting of Harold J. Coleman, Charles T. Crouch, Dr. George H. Sage, Dr. Basil C. MacLean, Thomas G. Spencer, Dwight S. Wetmore and Thomas R. White, council president.

Amendment to Social Security

WASHINGTON, D. C.—A bill to amend the Social Security Act for the purpose of permitting states, and political subdivisions and instrumentalities thereof, to obtain coverage for their officers and employes under the old-age and survivors insurance provisions has been introduced in the Senate by Mr. Kilgore.

HOSPITAL PLANNING?

The fourth in a series of six advertisements prepared to help you plan effective communications for new or modernized hospitals.

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Hospitals in L. A. Area Give 12 per Cent Salary Increase to Nurses

By ALDEN B. MILLS

Salaries of nurses in the Los Angeles area were raised by most of the larger hospitals by an average of approximately 12 per cent during October. The basic salary for general duty nurses, which had previously covered the range from $155 to $170, is now $175 to $190 for a 48 hour week. An extra $5 per month is being paid by many hospitals for the afternoon and night shifts.

The advance from $175 to $190 is to be made in steps of $2.50 per month each six months over a three year period. Some of the hospitals are and some are not giving credit for experience which nurses have had in other hospitals.

For head nurses, the range is from $190 to $205; for supervisors, from $205 to $220, for supervisors with college degrees, from $210 to $225. Operating room supervisors (and in some cases delivery room supervisors) have a range of $250 to $275. Nurses who work in the operating and delivery rooms are paid $10 above the base salary for floor duty nurses in some of the hospitals.

For nurse attendants who give patient care, the suggested range is from $120 to $150 with $5 extra for the afternoon and night shifts. Utility maids have a range of $115 to $125. Orderlies are being paid $140 to $165.

In the dietary department, the salaries suggested by the special salary survey committee of the Hospital Council of Southern California are: tray girls, $115 to $125; dishwashers, $115 to $160; head dishwasher, $125 to $170; dietitians (not including the chief dietitian), $175 to $215.

For regular laundry workers, a scale of $115 to $125 per month is recommended. The rate for maids is set at $115 to $125 and for porters, from $115 to $135. Assistant housekeepers are rated at $130 to $165 and housekeepers in hospitals of about 100 beds, at $175 to $250.

In the engineering department the suggested ranges are: chief engineer responsible for electric generating plant, $250 to $400; licensed engineers with general experience, $200 to $225; carpenters doing finished work, $185 to $225; painters, $185 to $200; gardeners, $175 to $200; routine maintenance men, $140 to $165.

Ordinary pharmacists are listed at $190 to $275 but a check of several hospitals reveals that most of them are paying from $250 up. The salary committee did not make any recommendations regarding technicians, medical records librarians, administrative and business staffs or most of the department heads.

Howard Burrell, attorney for the Association of California Hospitals, has advised the hospitals of the state that they cannot raise salaries without getting prior approval of the regional War Labor Board if they wish the increased cost to be reflected in their charges to the federal government for E.M.I.C. and other cases for which the hospitals bill the government.

Bon Secours Gets $1,107,000

A $600,000 public campaign to establish the Bon Secours Hospital in Lawrence, Mass., closed with subscriptions amounting to $1,107,000. Hailed by the Most Rev. Richard J. Cushing, D.D., Archbishop of Boston, as a "magnificent tribute to the people of Lawrence," the fund-raising movement will make possible the construction not only of the new 100 bed community hospital, but also of a school of nursing education and residence for nurses. Design of the hospital and nurses' home is by Curtin and Riley, hospital architects of Boston. Fund-raising counsel to the hospital was Will, Folsom and Smith of New York. The hospital will be operated by the Sisters of Bon Secours, who have hospitals in Baltimore, Philadelphia and Washington.

Maine Superintendents Attend Institute

The first course in hospital administration to be held in Maine was attended by 28 administrators from hospitals all over the state. This three day intensive institute was held at Colby College, Waterville, the latter part of September as part of the college's program of adult education. The curriculum was based upon the central idea of sound administrative practice in the human and public relations phases of the hospital administrator's duties, particularly as applied to problems of the average Maine hospital. The students lived on the campus and worked intensively from 9 a.m. to 5 p.m. each day. So successful were the results of this first course that it is planned to continue the institute each year.

The course was under the direction of Frank E. Wing, director, New England Medical Center, Boston. Serving with Mr. Wing on the faculty were Dr. Joseph C. Doane, medical director, Jewish Hospital, Philadelphia, past president of the American Hospital Association; Abbie E. Dunks, assistant director, New England Medical Center, Boston, and a trustee of Simmons College; Oliver G. Pratt, director, Salem Hospital, Salem, Mass., past president, New England Hospital Assembly, and Raymond P. Sloan, editor, The MODERN HOSPITAL.

Enrolled as students were: Doris A. Abbott, superintendent, Redington Memorial Hospital; Henrietta Altman, assistant administrator and superintendent of nurses, Augusta General Hospital; Mabel Brackett, superintendent, St. Andrews Hospital; W. S. Briney, superintendent, Central Maine General Hospital; Fannie Burnham, Goodall Hospital, Inc.; Evelyn M. Chamberlain, superintendent, York Hospital; Adam M. Beaulieu, Presque Isle General Hospital; Arthur H. Cole, manager, Maine Eye and Ear Infirmary; Frank C. Curran, assistant, Eastern Maine General Hospital; Clare Donahue, director of nurses, Presque Isle General Hospital; Pearl R. Fisher, administrator, Thayer Hospital; Dorothy T. Folta, superintendent, New Milford Hospital; Helen Goodwin, Rumford Community Hospital; Louette MacLeod, superintendent, Camden Community Hospital; Beatrice C. Macaulay, assistant to the comptroller, Central Maine General Hospital; Edith Masterman, superintendent, Dean Memorial Hospital; Eva L. Morris, Brightlook Hospital; Mary A. Morris, administrator, Miles Memorial Hospital; Lillian Nash, administrator, Gardiner General Hospital; Elizabeth O'Connor, executive secretary, Central Maine General Hospital; Christina J. Oddy, director of nursing, Maine General Hospital; Ernest S. Odlin, assistant administrator, Maine General Hospital; Arthur W. Seepe, auditor, Thayer Hospital; Sister M. Annunciata, administrator, Mercy Hospital; Sister Mary Mercy, office manager, Mercy Hospital; Anna Wild, administrator, Mt. Desert Island Hospital; Sister Gertrude, superintendent, Sisters' Hospital; Sister Mary Edmond, assistant, Sisters' Hospital.

E.M.I.C. Cares for 1,000,000

Applications for E.M.I.C. aid are still being received at the rate of 35,000 a month, according to a report from the Children's Bureau. The program will continue until whatever date Congress establishes for its termination; thereafter, care for all cases then authorized—including care for the first year of life of infants born under the program—will be completed, the report states. More than a million cases have been handled since the program started, including 650,000 babies born, 250,000 mothers who received prenatal care, and 100,000 sick babies. Average maternity case cost was under $100, although some have gone as high as $1000, in the case of mothers who were dangerously ill. Nine out of 10 E.M.I.C. babies were born in hospitals, the report said.

Hospital Commission Reports Progress in State Surveys

Members of the Commission on Hospital Care at a first meeting in Philadelphia discussed the rôle of the general hospital in the care of all types of illnesses, the provision of hospital service for the rural population, relationships between hospitals and hospital bed-population ratios.

A progress report revealed that all 48 states have taken some action toward making a hospital survey. Of these, 22 states and the District of Columbia actually have surveys underway. All states making surveys are using the schedules of information and other work materials prepared by the Commisison on Hospital Care.

Coding of the information taken from the hospital schedules of information is now in process in Chicago.

Socio-economic studies being conducted by the commission staff are serving to crystallize many of the problems and will play a part in the planning of future hospital service.

The commission plans frequent future meetings to discuss other problems, such as the quality of medical care to be maintained in hospitals; the problem of improving hospital care for Negroes; scope of each of the various types of nursing services, such as professional, practical, visiting and public health; the problem of in-service education; out-patient or ambulatory service; place of the nonprofit hospital in the future; determination of a formula for dividing the responsibility for the provision of hospital service by local, state or federal governments.

N. Y. U.-Bellevue Reveal Program

The new joint New York University and Bellevue Medical Center which is to be built within a year or two will offer free care for indigent patients in Bellevue's new hospital, and group practice care for patients in the moderate and low income classes under a pre-payment plan in the university hospital and clinic.

Of the proposed $33,000,000 needed to construct the new municipal center, New York University will shortly announce a campaign to raise $15,000,000 to cover the cost of N.Y.U. buildings and their equipment plus maintenance for the first five years. The Bellevue plans, which call for an $18,000,000 development, will include a new 25 or 30 story hospital building and a new nurses' hospital and training school. Under this program 3200 to 3400 beds will be available.

Another important feature will be the training of doctors under New York University's new curriculum. Under this program medical training will be reduced from eight to seven years, stress will be put on the doctors' social responsibility and new emphasis will be placed on preventive medicine. Included in the plan is an Institute of Forensic Medicine which will be operated jointly by the university and the medical examiner's office. Here N. Y. U. will conduct classes and research on methods of improving public safety, effects of poison and causes of sudden death.

$500,000 for Cancer Research

A grant of $500,000 for cancer research has been made by the American Cancer Society from money received in this year's campaign. This will be divided, according to Dr. C. P. Rhoads, chairman of the research committee formed by the National Research Council in cooperation with the society, among chemical, biological and clinical research and research in physics. The sum of $50,000 is recommended for fellowships to attract to cancer research men being released from the armed services and war-time research activities.

Blue Cross Plans Urged to Enroll Veterans Individually

Problems created by reconversion of war industries and returning veterans were chief subjects for discussion at the conference of Blue Cross plan executives in New York City October 29 to November 1.

John Mannix, chairman of the Blue Cross commission of the A.H.A., urged heads of 85 plans to permit veterans to enroll as individuals and bring their families under Blue Cross protection as a demonstration of the public, nonprofit character of the Blue Cross movement. A number of plans have already provided this privilege for veterans, C. Rufus Rorem, director of the commission, reported.

The plans have made it possible for war workers to continue Blue Cross membership during reconversion layoffs, even when workers and their families move from one part of the country to another, Rorem stated. Inter-plan reciprocity agreements have also made more than half the total Blue Cross membership eligible to receive hospital benefits in any hospital in the country, it was brought out.

Of 19,000,000 members enrolled in 85 Blue Cross plans, 2,000,000 are also protected for medical and surgical service through affiliated medical service plans. it was reported at the conference.

COMING MEETINGS

AMERICAN MEDICAL ASSOCIATION, House of Delegates, Palmer House, Chicago, Dec. 3-6.

ARKANSAS HOSPITAL ASSOCIATION, Hotel Albert Pike, Little Rock, May 17-18.

ASSOCIATION OF CALIFORNIA HOSPITALS, San Francisco, April.

HOSPITAL ASSOCIATION OF NEW YORK STATE, Hotel Pennsylvania, New York City, June 10-12.

HOSPITAL ASSOCIATION OF PENNSYLVANIA, Hotel Bellevue Stratford, Philadelphia, April 24-26.

IOWA HOSPITAL ASSOCIATION, Hotel Fort Des Moines, Des Moines, April 15-17.

KENTUCKY HOSPITAL ASSOCIATION, Hotel Brown, Louisville, April.

LOUISIANA HOSPITAL ASSOCIATION, Hotel Washington-Youree, Shreveport, March 22.

MID-WEST HOSPITAL ASSOCIATION, Hotel President, Kansas City, April 24-26.

NATIONAL ASSOCIATION OF METHODIST HOSPITALS AND HOMES, Morrison Hotel, Chicago, Feb. 6-7.

NATIONAL CONFERENCE OF SOCIAL WORKERS, Buffalo, N. Y., May 19-25.

NEW ENGLAND HOSPITAL ASSEMBLY, Hotel Statler, Boston, March 11-13.

NORTH DAKOTA HOSPITAL ASSOCIATION, Hotel Ryan, Grand Forks, May 9-10.

OHIO HOSPITAL ASSOCIATION, Hotel Deshler-Wallick, Columbus, April 2-4.

TEXAS HOSPITAL ASSOCIATION, Hotel Texas, Fort Worth, March 21-23.

TRI-STATE HOSPITAL ASSEMBLY, Palmer House, Chicago, May 1-3.

UTAH STATE HOSPITAL ASSOCIATION, Salt Lake City, Dec. 6.

WISCONSIN HOSPITAL ASSOCIATION, Hotel Schroeder, Milwaukee, February.

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$6,500,000 Raised by Nine Eastern Hospitals for New Buildings

Nine eastern hospitals, reporting on their respective expansion projects, have exceeded $6,500,000 in their efforts to raise funds, three of the institutions having surpassed their announced goals.

The $275,000 building fund of Laconia Hospital, Laconia, N. H., has reached a total of $425,000. Most of the ground floor of the new pavilion and 14 private rooms on upper floors have been subscribed for by Scott and Williams, Inc., and five of its officers and directors.

Enlargement of Ossining Hospital, Ossining, N. Y., has been assured by the completion of its $300,000 building fund campaign which resulted in a total of $338,000.

For the second time in five years the Manchester Memorial Hospital, Manchester, Conn., has found it necessary to enlarge its capacity. It is concluding a $500,000 campaign to finance an addition which will enable it to accommodate 168 patients. A total of $403,000 has already been realized.

A subscription of $330,000 has been realized in the $350,000 building fund campaign of Clinton Hospital, Clinton, Mass. A new main building, which will increase the capacity to 120 patients, will be constructed soon.

More than $600,000 has been subscribed to the half million dollar building fund for Memorial Hospital, Pawtucket, R. I. The expansion project will add 92 beds to the normal capacity of the hospital through the construction of two two story private wings and the reconstruction of the present private pavilion.

In a joint appeal for $2,000,000, Harrisburg Hospital and Polyclinic Hospital of Harrisburg, Pa., recently obtained subscriptions totaling $2,133,000. The former will increase its capacity to 416 beds and the latter will add 92 beds to its normal capacity.

St. Francis Hospital, Hartford, Conn., has announced that its $2,000,000 building fund has reached $1,899,000. The extensive enlargement project, designed to increase the hospital's capacity to 700 patients, was undertaken under the leadership of the Most Reverend Maurice F. McAuliffe, who died recently.

Framingham Union Hospital, Framingham, Mass., is completing a program to finance the construction of a four story addition which will increase its capacity to 150 patients, excluding infants. The estimated cost is $600,000, and $475,000 has already been subscribed.

Bradley Memorial Hospital, Southington, Conn., will enlarge its normal capacity from 10 beds to 45 beds following a recent capital fund campaign for $250,000. Total subscriptions reached $257,000.

All of the fund-raising projects were under the direction of Will, Folsom and Smith of New York.

Start New Nurses' Home

Mount Sinai Hospital in Chicago recently observed the laying of the cornerstone for its new $750,000 nurses' residence and educational building. The new building will be seven stories high and will contain 220 rooms for student and graduate nurses and suites for supervisors and other faculty members. Immediately adjacent to the hospital, the building will be connected to it by overhead and underground passages. A. Epstein is the architect.

Hold Second A.C.H.A. Institute

Officers and regents of the American College of Hospital Administrators held their second educational program for members on "Selected Problems in Hospital Administration" November 12-16 at Purdue University, Lafayette, Ind. Charles E. Prall, director of the joint commission on education, served as program coordinator.

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LARGEST MANUFACTURERS OF LAUNDRY SUPPLIES IN THE WORLD

Recommend Change in Administrative Setup at Los Angeles General

Although the County General Hospital advisory committee exonerated the administrative officers of the county-owned General Hospital at Los Angeles in the recent death of 14-year-old Pauline Estrada as the result of an error in medicines, Supervisor Leonard J. Roach offered a formal recommendation for a change in administrative policy. The death was the third similar tragedy to occur at the hospital.

To provide Los Angeles County with the most efficient administration procurable for its public institutions, Mr. Roach recommended the following three-point project for study and early determination:

"1. Establish the General Hospital as a single entity under the direction of an administrative head, preferably a doctor with hospital administration experience, who would report directly to the board of supervisors through its chief administrative officer.

"2. Place all institutions under separate directors responsible to the board of supervisors through their chief administrative officer.

"3. Realize that Los Angeles General Hospital, Rancho Los Amigos and Olive View Sanatorium are probably the largest institutions in the world of their particular types and that it seems nearly physically impossible that one man could competently administer all of these gigantic institutions and, in addition thereto, direct and manage all of the other charitable agencies in the county, including the Bureau of Public Assistance."

Confidence in the administrative officers, Arthur J. Will, county superintendent of charities, and LeRoy Bruce, director of the hospital, was expressed by the hospital advisory committee in its investigation, and Mr. Will was commended by Mr. Roach.

The Estrada child was reportedly given an intravenous injection of 20 per cent sodium chloride instead of a normal saline solution which had been prescribed. The doctor and nurse involved face a manslaughter charge.

136 Nurse Anesthetists Register for Institute

One hundred and thirty-six members, representing 34 states and Hawaii, attended the first institute for instructors in schools of anesthesiology conducted by the American Association of Nurse Anesthetists at the Hotel Knickerbocker, Chicago. Planned primarily for instructors, so many requests were received from other members of the association that registration was extended to all active members.

Featuring the program was a panel discussion, "The Nurse Anesthetists' Plans for Tomorrow's Responsibilities." Dr. Malcolm T. MacEachern, of the American College of Surgeons, served as coordinator of the panel, members of which represented physicians, surgeons, hospital administrators, schools of nursing and the nurse anesthetists.

Dr. Joe Park, assistant professor of education at Northwestern University, Evanston, as education expert, lectured on "Principles and Methods of Teaching," "Curriculum Construction" and "Tests and Measurements." Instructors from various schools presented lectures as they offer them in class after which Doctor Park commented on the method of presentation, place in the curriculum and the use of various teaching aids.

The anesthesia records prepared by a special committee of the association were presented and discussed, and Dr. Edwin P. Jordan of the American Medical Association spoke on "The Essentials in Writing a Paper on Anesthesia."

Certificates were presented at the final session. Esther Myers Stephenson of Winchester, Mass., was chairman of the institute.

Western Reserve Offers Three-Point Refresher Course for Doctors

Details of a special training program to accommodate three different groups of doctors in need of refresher courses have been announced by the School of Medicine at Western Reserve University, the Academy of Medicine and 18 hospitals which comprise the Cleveland Hospital Council.

According to Dr. Robert F. Parker, associate professor of medicine at Western Reserve University School of Medicine and chairman of the university's committee setting up the medical school's contribution, the program will be flexible enough to meet the needs of the graduate physician whose hospital training was interrupted, the doctor who requires a refresher course in civilian medical practices and the civilian doctor who wants an intensive brush-up on new technic.

The first phase of the program will be handled by individual hospitals. The second phase has been developed for former Army and Navy doctors who have completed two or more years of hospital training; for these, the medical school will offer a three month refresher course covering the fields of medicine, pediatrics and general surgery. Students may enroll on the first of any month in which there is a vacancy. The third phase is a "graduate fortnight" for both former military medical officers and the civilian doctor who has been too hard-pressed during the war years to keep up with latest developments. This phase is under a special committee of the Academy of Medicine.

Industry Supports Grace-New Haven Hospital

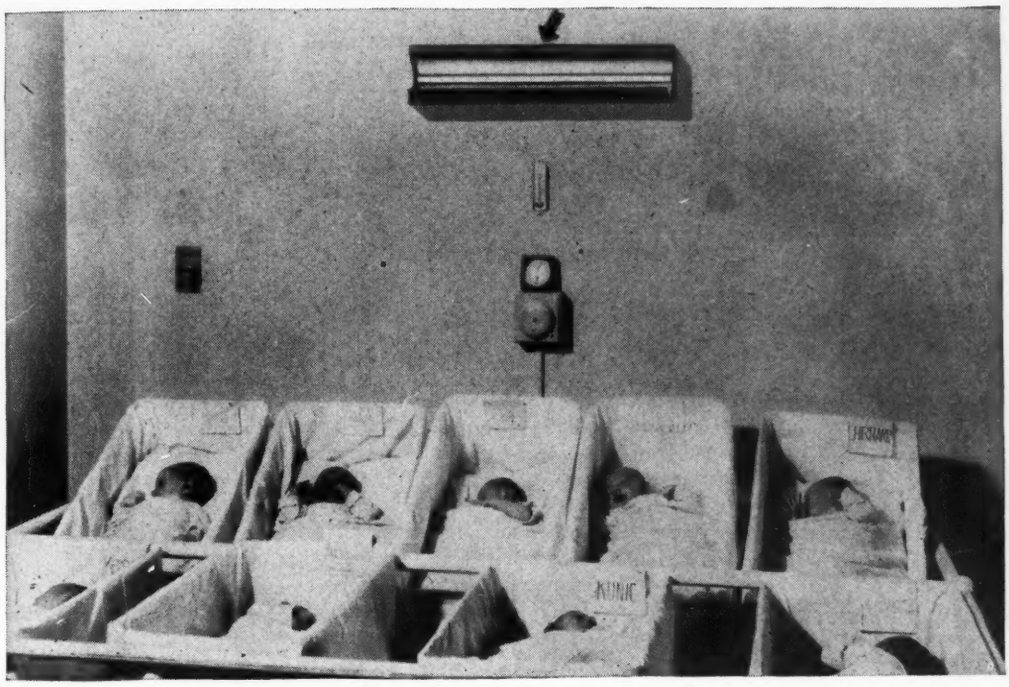
The first subscription to the recently launched Grace-New Haven Community Hospital's $5,000,000 building fund was a contribution of $250,000 by the Winchester Repeating Arms Company Division of Olin Industries, Inc. The company selected the major part of the sixth floor of the modern 450 bed hospital, to be built near the present New Haven Hospital, as a memorial to its employes who served in World War II.

The doctor's memorial committee has pledged itself to raise $266,400 from the medical profession in the New Haven area for the construction and equipment of the entire laboratory department and the staff suite of the new unit.

Douglas Orr of New Haven is architect for the new hospital, which is to succeed the present Grace Hospital and the New Haven Hospital. The building fund campaign is being directed by Will, Folsom and Smith of New York.

Extend THE PROTECTION

Against Infection from Air-borne Organisms



YOU can now provide your patients with further protection against respiratory infection—can disinfect the air in nurseries, contagion wards and surgeries—by utilizing the potent germicidal energy emitted by G-E Germicidal Lamps.

The importance of preventing epidemics and quarantines is readily recognized by hospital officials. In spite of rigid asepsis, pathogenic organisms emanating from patients, bedding or other infectious sources may float on air currents to reinfect other patients.

General Electric by perfecting G-E Germicidal Lamps, offers you an abundant source of that band of ultraviolet energy capable of killing air-borne bacteria and viruses—an effective and economical means of disinfecting the air of hospital rooms.

The Council of Physical Medicine of the American Medical Association already has accepted for hospital use a number of fixtures using G-E Germicidal Lamps.

Medical literature reports ample clinical evidence of material reductions in respiratory infections where G-E Germicidal Lamps were installed. West Suburban Hospital in Oak Park has employed germicidal radiation for more than six years in their nursery. Actual tests show a lowering in bacterial counts since the installation and no epidemics have occurred.

Write today for illustrated booklet and complete details on the G-E Germicidal Lamps to General Electric, Nela Park, Cleveland 12, Ohio.

A word of caution: The potent energy of G-E Germicidal Lamps will not only kill air-borne bacteria, but can cause conjunctivitis and dermal erythemia on direct exposure.

G-E GERMICIDAL LAMPS

GENERAL ELECTRIC

Navy Tells Plan for Disposition of V-12 Medical Students

By EVA ADAMS CROSS

WASHINGTON, D. C.—Approximately 5700 medical and 1450 dental students of the Navy V-12 program will remain on active duty until the end of the current semester, according to an announcement of the Navy Department. Another 1500 V-12 students entering medical or dental school this fall will remain on active duty for one term.

Medical and dental students, it is reported, will be returned to inactive duty as enlisted men and will subsequently receive probationary commissions in the Naval Reserve and be retained on inactive duty.

The remaining 25,500 students in the Navy V-12 Program will either be graduated or continue their training in college as apprentice seamen on active duty. Final disposition of all students in the program will be made by June 1946, it is reported.

At 69 of the 124 colleges and universities throughout the country with V-12 and NROTC units this training terminated November 1. Training will continue at 42 NROTC units and 13 V-12 units in the program and at 10 newly established NROTC units.

Cooper Heads Hospital

Following the consolidation of Presbyterian Hospital, New York City, with the New York Orthopaedic Dispensary and Hospital, previously reported in these columns, announcement has been made of the appointment of Charles P. Cooper, president of Presbyterian Hospital, to serve as head of the new corporation.

Other officers who will serve with Mr. Cooper until the corporation's first annual meeting in March are: vice presidents, William E. S. Griswold Sr., Carl Tucker, William H. Harkness and John Sloane; treasurer, Cornelius R. Agnew; assistant treasurer, Bayard W. Read; secretary, Matthew C. Fleming, and assistant secretary, William E. S. Griswold Jr.

Add Floor to Reese Hospital

A fifth floor to house the hematology laboratories is being added to the south wing of the Research Institute at Michael Reese Hospital, Chicago, through a gift from Harry Sherman. This gift, together with the support given by the Hematology Research Foundation, will aid the department in expanding its research in blood diseases, particularly in the study of leukemia and Hodgkin's disease.

New York Hospitals Join Refresher Course for Returned Doctors

Five thousand medical officers returned from the armed services may soon be seeking postgraduate instruction in New York City, according to Dr. Willard C. Rappleye, dean of the College of Physicians and Surgeons of Columbia University and a trustee of the United Hospital Fund of New York.

This number is "well beyond the capacity of the hospitals and schools to provide for adequately," Doctor Rappleye believes.

An effort to meet the need for providing refresher courses for doctors returning from war service is being made by the College of Physicians and Surgeons of Columbia University through the expansion of its postgraduate programs in 19 of the voluntary and municipal hospitals in New York and one in Jersey City, Doctor Rappleye has disclosed. These institutions, of which 13 are voluntary hospitals joined in the United Hospital Fund, are cooperating fully in the effort of the university to provide long-term, full-time residency training in all the clinical fields. Every hospital affiliated with the university is planning to increase the number of its residencies, consistent with available clinical material for such training.

answers to your Questions about Alfax

The talk of the Industry – Turco's amazing new dishwashing compound, Alfax, brings us a flood of questions. Here are the answers.

Q WHAT DOES ALFAX DO that ordinary dishwashing compounds won't do?

A QUITE A FEW THINGS. But probably the most important and spectacular is that ALFAX will reduce germ colonies that form on dirty dishes by more than 50 per cent, well below the most exacting demands of the toughest health departments.

Q JUST WHAT DOES THAT MEAN? How do you know, and how did you find out?

A SCIENTIFIC TESTS WERE MADE. Plates were washed 15 days in an average dishwashing machine charged with a popular and commonly used type of commercial dishwashing compound. Yet, at the end of 15 days the plates still harbored an average of 20 colonies of bacteria per plate*

Q WHAT HAPPENED WHEN YOU TESTED ALFAX?

A IT WAS AMAZING. The same test was then repeated in the same dishwashing machine, but this time using ALFAX. At the end of the test, the report showed an average count of only 9 colonies per plate – more than 50 per cent reduction – a margin of safety well within the most stringent health laws.

Q HOW IS ALFAX ABLE TO DO THIS?

A THROUGH SURFACE CHEMISTRY. The molecular structure illustrated above is symbolic of what Turco scientists mean by *Surface Chemistry*. Every cleaning factor is present in correct balance with every other cleaning factor. It is by this brand new balance that Turco scientists perfected ALFAX Dishwashing Compound.

Q WHAT DO THESE CLEANING FACTORS DO?

A EACH DOES A DIFFERENT BUT IMPORTANT JOB. LIKE THIS:

WC – Water Conditioning instantly traps the minerals in the hardest water, prevents them from interfering with the efficiency of other cleaning factors, and effectively prevents them from being redeposited as scale – scale that dulls dishes and builds germ nests – not only on dishes, but in dishwashing machines. *WA* stands for *Wetting Action*. The super-wetting action of ALFAX comes *immediately* into play, spreads the wash water over the entire surface of the dish, allowing the cleaning factors to go to work on the dirt – not just some of the dirt, but *all* of the dirt. Immediately thereafter, *EA* – the *Emulsifying Action* in ALFAX blasts the oils and greases into infinitesimally tiny globules, suspends them and prevents their redeposition on the plate or in the dishwashing machine. Simultaneously, *CA*, or *Colloidal Activity*, splits solids into equally minute particles which are easily removed in the water. The other factors involved in *Surface Chemistry* are: *SV – Saponifying Value*, which is the ability to convert organic fats and oils into the soluble soaps; *TA – Total Alkalinity* is the total amount available for cleaning; *BI – Buffer Index* is the ability to absorb either alkaline or acid soil to prolong solution efficiency; *pH* – a yardstick by which the energy of alkalinity may be measured; *SA – Solvent Action*, the ability to put soil and dirt into solution.

Which leaves one factor, most important of all, *RE*. *RE* stands for *Research & Experience*, the combined know-how that Turco men have gained through the past two decades. It is *RE* that has, through balanced *Surface Chemistry*, produced ALFAX. The real worth and benefit to you of Turco's *RE* will become immediately apparent when you use ALFAX in your dishwashers.

** Note: For the complete story on the sanitary value of dishwashing compounds built as ALFAX is, see "Industrial and Engineering Chemistry, Vol. 29, page 421."*

Many dishwashing compounds *sound* alike – on paper. But we'd like to give you a free demonstration, or send you a free booklet with complete details about ALFAX, and how ALFAX will work in your own equipment. Call your nearest Turco representative for a demonstration, or write Dept. MH-11.

Superintendents Harry Benjamin, Donald C. Smelzer, Lucius R. Wilson and May A. Middleton admire the Blue Cross art exhibit at Wanamaker Galleries, Philadelphia.

Philadelphia Blue Cross Sponsors Art Exhibit

In observance of its seventh anniversary the Associated Hospital Service of Philadelphia sponsored the first art exhibition to be held by a Blue Cross plan. "Portraits of Babies" was staged at the Wanamaker Galleries, John Wanamaker Store, in connection with the Art Directors Group of Philadelphia. A special feature was a watercolor portrait of the Cirminello quadruplets, born last November in Philadelphia's Lying-In-Hospital. These are the first quadruplets born to any Blue Cross subscriber.

Other exhibits included work in all media—oils, water colors, drawings, pastels, etchings, miniatures, photography and sculpture. The subject of babies was selected because of the fact that millions of men and women in the armed forces are returning to civilian life and are looking forward to establishing their own homes and families.

According to E. A. Van Steenwyk, executive director of Associated Hospital Service, maternity care will be a more important feature of Blue Cross than ever before. He anticipates that as much as one third of all the plan's hospital cases within the next year will be maternity cases. With this in mind the board of directors of the Philadelphia Blue Cross have set aside a special reserve of $500,000 for this purpose.

Seeks Funds for Expansion

Children's Hospital of Akron, Ohio, has inaugurated a $610,000 capital fund campaign for expansion purposes. In the 1944 outbreak of infantile paralysis the hospital took care of 208 infantile paralysis cases. Serving 16 counties in Ohio, Children's Hospital is one of the six hospitals in the state authorized to accept state-aid crippled children's cases.

No, this is not double talk! When *unfortified* dextrose infusions are administered to maintain the caloric requirements of the body, this intake is, of course, pure carbohydrate. Since Vitamin B factors are recognized as being essential to the proper metabolism of carbohydrates, such parenteral feeding, in a patient already having a reduced store of the B complex group, may act to further *subtract* from that store and result in an acute deficiency. • In Beclysyl, the potency of the B factors is now increased so that each liter contains *10* mg. of Thiamine Hydrochloride, *5* mg. of Riboflavin and *50* mg. of Nicotinamide in addition to the dextrose in a saline solution or in chemically pure water. This solution, while suitable in all cases requiring parenteral administration of dextrose in saline, is particularly indicated in postoperative states associated with nausea, vomiting, hyperemesis gravidarum, and in cases where intestinal obstruction or other intra-abdominal disease causes persistent vomiting. • Each bottle of Beclysyl (coated with a black lacquer to protect the riboflavin from the deteriorating action of light) is thoroughly tested for sterility and freedom from pyrogens and is easily dispensed with the standard Abbott Venoclysis Equipment. ABBOTT LABORATORIES, North Chicago, Ill.

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(ABBOTT'S THIAMINE, RIBOFLAVIN AND NICOTINAMIDE IN DEXTROSE SOLUTIONS)

California to Survey Needs of Chronic, Convalescent Patients

A survey of the need for chronic and convalescent care facilities in California has been undertaken by the Association of California Hospitals through a special committee headed by Dr. J. A. Katzive, administrator of Mount Zion Hospital, San Francisco. All member hospitals are asked to list the patients who were in the hospital on October 15 who could be cared for in a convalescent hospital, a chronic disease hospital, by nursing care only or by having custodial care.

The board of trustees recognizes, according to Doctor Katzive, "that we are approaching a period when the costs of medical care must be reduced to the minimum. Previous studies have shown that the cost of care in convalescent and chronic institutions is approximately 50 per cent of the cost of care rendered in acute hospitals.

"In connection with federal funds to be made available under S. 191, if enacted, it is important that we have at hand information indicating whether additional health facilities are needed so that we can take advantage of any federal aid available."

Rhode Island Hospital Receives Memorial Gifts

Many substantial gifts to create memorials in the new Rhode Island Hospital, Providence, have been made to the $5,000,000 building fund by which the original hospital structure, built in Civil War times, is to be replaced. Stephen O. Metcalf has subscribed $250,000 to build and equip the orthopedic and surgical clinics and the social service suite as memorials to Dr. Murray S. Danforth, his son-in-law, and Lt. Stephen M. Danforth, his grandson, who was killed in action in a massive invasion rehearsal over France last year.

An anonymous contributor subscribed $107,400 to provide new quarters for the School of Nursing. Members of the Rhode Island Hospital Nurses' Alumnae Association voted to subscribe $60,000 for the administration unit of the school of nursing which will be constructed on the ground floor of the new 10 story building.

The design of the new hospital, which will have a capacity of more than 800 beds in addition to a large out-patient department, has been entrusted to Cooolidge, Shepley, Bulfinch and Abbott of Boston with Will, Folsom and Smith of New York serving as fund-raising counsel for the project.

Public Health Service and Advisory Agencies Adopt Joint Program

A meeting of the National Advisory Health Council and the National Advisory Cancer Council was held recently at the U. S. Public Health Service, Bethesda, Md., to consider the relationship of the Public Health Service with the proposed National Research Foundation or any over-all research body which bills now pending would create.

After a presentation of opinions, the following motions were passed unanimously by the councils:

1. That proposed legislation should be amended to include statements to the effect that autonomy in the development and conduct of their research programs should be maintained by those governmental agencies now engaged in such activities.

2. That there should be governmental representation on such boards and advisory committees as may be set up in connection with the proposed National Research Foundation.

3. That the joint report and recommendations of the councils be brought to the attention of other scientific groups, both public and private, now considering the proposals for a National Research Foundation.

More Hospitals Sound Condition with

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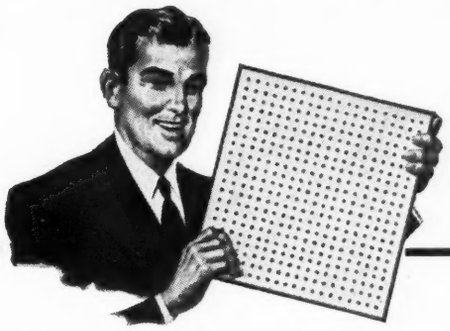
Than with Any Other Acoustical Material



No other sound conditioning product can match that popularity . . . nor equal the Acousti-Celotex 20 year record of proved performance in major hospitals in every state.

This leadership stems from the Celotex *rigid quality control in manufacture* . . . plus *painstaking installation control* by professionally trained distributors.

That's why the majority of hospitals *insist* on Acousti-Celotex*—the *original* and *genuine* perforated fibre tile—when they want to solve their noise-quieting problems. They know *only* Acousti-Celotex assures them of—

1. Guaranteed Efficiency. Because Acousti-Celotex is backed by the reputation and resources of The Celotex Corporation, world's *only* manufacturer of cane fibre acoustical products, every Acousti-Celotex distributor can and does *guarantee* results.

2. Permanency. The sound absorbing properties of Acousti-Celotex are *not* affected by repeated painting or enameling. Hospital installations 20 years old and older *prove* this!

3. Exclusive Ferox Process. Only Acousti-Celotex has it! This special treatment protects the long, tough, interlocking cane fibres of every Acousti-Celotex tile against damage from dry rot, fungus and termite attack.

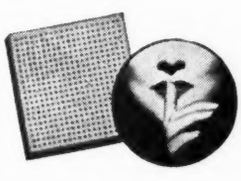
4. Outstanding Leadership. Acousti-Celotex is the oldest and the greatest name in sound conditioning. Its leadership has *never* been seriously challenged. Such success is *proof* of product superiority.

Remember, too, the same care taken to maintain the high quality of Acousti-Celotex is exercised in selecting and training Acousti-Celotex distributors.

So consult *your* local Acousti-Celotex distributor with confidence. His Celotex training thoroughly prepares him to diagnose all types of sound conditioning problems . . . to reduce noise to a gentle hush that soothes nerves of patients and staffs, hastens recoveries and promotes efficiency of workers. Feel free to call him in *without obligation.* Or drop a note to *Celotex, Dept. MH-1145, Chicago 3, Illinois.* It will bring a trained Sound Conditioning Expert to your desk.

FREE! "The Quiet Hospital"

Timely! Interesting! Informative! For *your* FREE copy of this fact-packed illustrated booklet, write today to: The Celotex Corporation, Dept. MH-1145, Chicago 3, Illinois.



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Doctors Prescribe for Better Teamwork Between Doctors and Nurses

The traditional teamwork of doctors and nurses must be improved if it is to promote better health for the American people, according to a recent nationwide survey of medical opinion conducted by Edward L. Bernays for the *American Journal of Nursing.*

Answers to such questions as whether professional nurses have too much or too little education for their duties; whether one, two or three levels of nurses should be educated for different grades of duties, and whether doctors and nurses really understand each other's professional points of view are summarized by Bernays, in the November issue of the *Journal.*

Prescribing for the future, physicians recommended three general measures.

1. Exchange of information and greater cooperation, as for instance by sharing responsibility for hospital administration.

2. Changes in education to provide for a definite stratification into such levels as practical nurses, professional nurses for staff duty and professional nurses for executive or administrative work.

3. Better distribution of the costs of nursing care, based on careful study of the economics of nursing. "Salaries of nurses are too low," wrote one physician, "but the public complains of the cost of special nursing." That the hazards of periodic unemployment, resulting in a low annual income in spite of good rates per day, are sending many free lance nurses into the greater security of institutional work was brought out in a number of replies. Hourly nursing service for patients not needing full-time care was one solution offered.

Extension of the Social Security Act, or enactment of other federal legislation, to include nursing services was predicted by about one third of those replying.

U. of C. Students Listed

Eight new members are enrolled in the current course in hospital administration at the University of Chicago. The group, which represents seven different states, as well as one South American country, presents a variety of backgrounds. The new members are Elmo Carpenter, Oakland, Calif.; Dr. Jacob Helms, Grand Rapids, Mich.; Avery M. Millard, Bradenton, Fla.; Frank Raymond Shank, Chicago; Ralph W. Tarr, Summerfield, Kan.; Frederic R. Veeder, Morehead City, N. C.; Charles S. Billings, Topeka, Kan., and Dr. Osvaldo A. Quijada, Valparaiso, Chile.

Parran Offers Program of Medical Care for All

To combat chronic disease and to deploy medical forces more evenly, Surgeon General Thomas Parran, head of the United States Public Health Service, has developed an extensive six-point program which would reach to the heart of every rural and urban community.

Doctor Parran's plan would provide a sanitary environment for everyone; a nationwide network of hospitals and affiliated health centers; an expanded public health service; a federally aided program for health workers; publicly supported health and medical research, and a national assurance to every American of the health and medical care he needs. His program would be effected through either tax support or health insurance or a combination of both.

To provide even the smallest community with the benefit of metropolitan skill and knowledge, Doctor Parran proposes a nationwide network of hospitals and affiliated health centers with each state network having as its center one or more large base hospitals in metropolitan areas from which would radiate a series of smaller hospitals for less populated areas and from them a series of health centers or field stations for sparsely populated areas.

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STOX—*Granulated Bouillon*—*also works a miracle of flavor and provides extra B vitamins*

A "secret" of soups and sauces, Stox is rapidly winning the hearts of dietitians everywhere. Over and above its nutritive value and its amazing time- and money-saving features, Stox gives soups and sauces that magic savor.

This granulated bouillon has a hearty meat-like flavor that helps to stretch your meat supply. It enables you to give meatless dishes an appetizing meaty flavor—plus extra vitamin values.

Delicious as an instant clear bouillon, too! Once you use Stox in your menus, it will stay there.

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California Nurses to Ask 40 Hour Week

Hospitals in California will be operating on a 40 hour week as soon as more nurses are available if the California State Nurses' Association has its way. The directors of the association recently adopted a statement of objectives to be made operative "as soon as war-time regulations and postwar conditions permit."

The board declared that "all proper steps should be taken toward accomplishment as and when . . . conditions permit" of the following objectives: (1) that the minimum salary schedules as approved by W.L.B. be increased to reflect adequately the rise in living costs of approximately 30 per cent since 1941; (2) that a schedule of 40 hours per week, on a five day basis, be established "to provide fairer working hours and conditions comparable with those enjoyed by other professional and nonprofessional employes," and (3) that personnel practices, including vacation allowances, sick leaves, health programs and similar practices recommended by the association be established.

To achieve these objectives, the following immediate steps were recommended: salary increase of 15 per cent; 40 hour week as soon as the acute shortage of R.N.'s is relieved.

As reported elsewhere, the salary increases granted in the Los Angeles area are approximately 12 per cent for general duty nurses.

U.N.R.R.A. Completes Medical Program for Displaced Persons

An extensive program of medical care for the approximately 500,000 displaced persons remaining in assembly centers of U. S. occupied Germany has been completed by U.N.R.R.A. health officers, according to word received by the Washington Headquarters of the international relief and rehabilitation agency.

About 250 U.N.R.R.A. doctors and nurses will supervise the program which is in charge of the public health branch of U. S. Military Government. They will be assisted by qualified personnel selected from an estimated 400 doctors, dentists and nurses in the D.P. population; the staff will include also sanitation officers, nutrition experts and hospital technicians.

Because a severe winter with critical fuel shortages in Germany is anticipated, doctors are immunizing displaced persons for typhus, diphtheria, typhoid and small pox, and supplies of sulfa drugs are being stocked for pneumonia.

Rochester Council Sponsors Institute

A public relations institute for hospital personnel and trustees sponsored by the public relations committee of the Rochester Hospital Council was scheduled for November 14.

Dr. Robin C. Buerki, director of the Hospital of the University of Pennsylvania at Philadelphia, was guest speaker at the three sessions. Identical morning and afternoon sessions were held to accommodate all hospital employes.

The new film, "As Others See Us," was presented as a visual implement, tying in directly with subject matter of the program. The evening meeting was devoted to a "trustees' forum" conducted for the boards of directors and women's boards of managers.

Will Train Radiologists

Adoption of a program to provide three to six month review and refresher courses for radiologists who have been serving with the armed forces has been announced by the American College of Radiology's education commission. Radiologists enrolling in the courses will qualify for tuition and education allowances under the G.I. Bill of Rights, according to Lt. Cmdr. John D. Camp, chairman of the commission.

Florida Administrators Meet in Orlando

With the problems and uncertainties of the postwar era confronting all hospitals, the discussions on "What's Ahead for Florida's Hospitals" and "The Florida Blue Cross Plan—Its Progress and Aims" were of particular interest to those attending the annual meeting of the Florida Hospital Association in Orlando.

The former discussion was conducted by Prof. John M. Maclachlan of the department of sociology, University of Florida, Gainesville, and the latter by Rev. Paul L. Manning, vice president of the board of directors of the Florida Hospital Service, St. Augustine.

All sessions were held at Orange General Hospital, and the following officers were elected at the business meeting:

President-elect for 1946, Sister M. Alverna, supervisor, St. Mary's Hospital, West Palm Beach; treasurer, J. H. Holcombe, superintendent, Tampa Municipal Hospital; executive secretary, H. A. Cross, executive director, Florida Blue Cross Plan; trustees for term expiring 1948, W. A. Nelles, superintendent, Riverside Hospital, Jacksonville, and C. DeWitt Miller, superintendent, Orange General Hospital, Orlando.

Form Army Research Board

WASHINGTON, D. C.—An Army Medical Research and Development Board has been constituted in the office of the Army Surgeon General. It will be responsible for the planning and general supervision of all medical department research and development activities. Its membership will include the chiefs of the various professional services and divisions of the Office of the Surgeon General; the Air Surgeon; the Ground Surgeon; the chairman of the division of medical sciences, National Research Council (by invitation), and the chairman of the committee on medical research, Office of Scientific Research and Development (by invitation).

Urges Removal of Boric Acid

Dr. E. H. Watson, of Ann Arbor, Mich., recommends that boric acid be removed from use entirely in an article in a recent issue of the *Journal of the American Medical Association*. Doctor Watson, who is connected with the department of pediatrics and communicable diseases at the University of Michigan Medical School, says that the drug, which has caused the accidental deaths of several infants during the past few years, has been superseded by more effective germicides and preparations.

Flexner Sponsors Palestine Medical Plan

Plans are underway for the first medical school in Palestine, and a two year, countrywide campaign to raise $4,000,000 is in progress. The institution will be built on Mt. Scopus, Jerusalem, by the Hebrew University and Hadassah, the Womens' Zionist Organization of America.

Ira Hirschmann, vice president of the Metropolitan Television Company, and Mrs. Samuel J. Rosensohn, national treasurer of Hadassah, are co-chairmen of the fund-raising campaign committee.

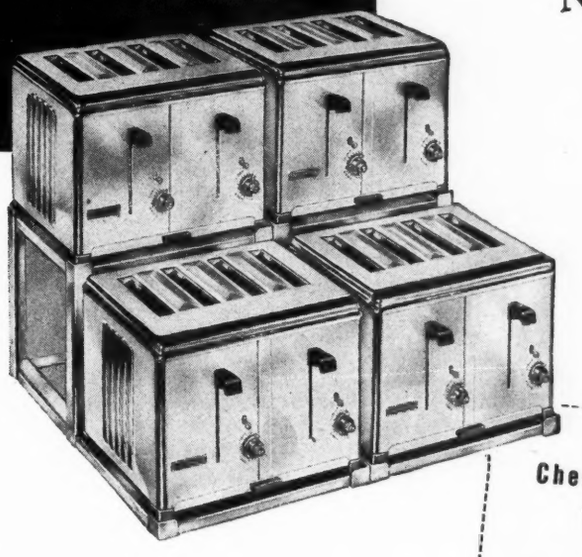
Dr. Abraham Flexner, noted authority on medical education, is heading a committee to sponsor the establishment of the proposed medical school and has said that he will invite outstanding American scientists to join the sponsoring group.

A.H.A. Issues New Booklet

In an effort to encourage strong and progressive state hospital associations, the American Hospital Association has issued a new booklet, "Organization of Local Hospital Groups." The booklet was prepared for the Council on Association Relations of the American Hospital Assocation by the committee on subdivisions which comprises J. Dewey Lutes, Carl P. Wright and H. J. Mohler.

Plan on a TOASTMASTER toaster for golden-brown uniformity in every slice!

No waste



No watching . . .

• Right! Every crisp, crunchy slice popped up by a "Toastmaster" toaster is exactly the made-to-order shade of brown you want. For once you adjust the degree of toasting to suit your taste, you can leave the rest to the exclusive "Toastmaster" Flexible Timer. This mechanical marvel *automatically* adjusts toasting time to make every slice *uniformly* golden-brown . . . without watching, without waste.

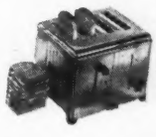
Your "Toastmaster"* toaster requirements will be satisfied as quickly as possible now that we are back in production. Meanwhile, there's no time like the present for including this efficient equipment in your modernization program. Your food service equipment dealer can help you with your plans, now.

TOASTMASTER *Toast*

The National Habit Wherever Folks Eat!

Check These TOASTMASTER Toaster Advantages

Capacity (16-slice model) over 1,000 slices an hour—in less than two feet of counter space! Other models to suit every volume requirement. *Flexibility* is offered by multiple-unit construction. Add 4-slice units to increase capacity. Or shift complete units to points where emergency toast production is desired. *Economy* results from no current waste, no pre-heating, and elimination of bread spoilage.



Take care of your "Toastmaster" toasters and they will serve you well. If you need repair parts, however, they are available through any of the 32 Authorized Toastmaster Products Service Stations or the factory.

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List New Hospitals and Additions for Veterans' Facilities

Nineteen new Veterans Administration hospitals and additions to 15 existing hospitals and four domiciliary homes will be built under an order approved by President Truman and announced recently by Gen. Omar N. Bradley. The new structures will cover a total of 15,276 beds, the announcement said, and all buildings will be permanent, fireproof construction. Size and location of the hospitals are as follows:

NEW HOSPITALS	BEDS		
	GM&S.	*T.B.*	*N.P.*
New Haven, Conn.	500		
Albany, N. Y.	1,000		
Buffalo, N. Y.	1,000		
Newark, N. J.	1,000		
Baltimore		300	
Washington, D. C.	750		
Gainesville, Fla.			1,000
Clarksburg, W. Va.	200		
Louisville, Ky.	750		
Decatur, Ill.	250		
Duluth, Minn.	200		
Southern Minnesota		200	
Iowa City, Iowa	500		
Omaha, Neb.	500		
New Orleans	500		
El Paso, Tex.			500
Oklahoma City, Okla.			1,000
Phoenix, Ariz.	200		
Cincinnati	750		

ADDITIONS TO EXISTING HOSPITALS	BEDS		
	GM&S.	*T.B.*	*N.P.*
Northampton, Mass.			314
Bedford, Mass.			400
Lebanon, Pa.			1,600
Atlanta, Ga.	133		
Downey, Ill.			164
Lincoln, Neb.		20	
Minneapolis, Minn.	150		
Sioux Falls, S. D.	150		
Biloxi, Miss.	50		
Gulfport, Miss.			164
Tuskegee, Ala.			164
Salt Lake City, Utah	50		
San Fernando, Calif.		150	
Portland, Ore.		150	
Roseburg, Ore.			164

ADDITIONS TO DOMICILIARY HOMES	*Beds*
Bath, N. Y.	100
Mountain Home, Tenn.	100
Bay Pines, Fla.	53
Dayton, Ohio	100

CONVERSIONS FROM GM&S TO T.B. HOSPITALS	*Beds*
Batavia, N. Y.	294
Lincoln, Neb.	280

This authority permits the Veterans Administration to make tentative site selections, but it will submit to the Federal Board of Hospitalization for its consideration and appropriate recommendation to the President requests for authorization to acquire the specific sites for the 19 new projects.

Contributions Inadvisable

Because voluntary hospitals are supposed to use any available funds for the charitable purpose of rendering care to needy people in distress, it was recommended during October by the executive committee of the Hospital Council of Southern California that such hospitals should not make contributions from the funds of the hospital itself to other charitable causes. "This advice does not apply," the committee declared, "to individual employes of the institution who may subscribe to any worthy cause if they desire, or to proprietary hospitals which for any reason feel that corporate contributions for charitable purposes will be a benefit to them."

Wins Gorgas Medal

Capt. Lowell T. Coggeshall, M.C., U.S.N.R., expert on tropical diseases, has been awarded the Gorgas Medal for his work in rehabilitating victims of filariasis and malaria, it has been announced by the Association of Military Surgeons of the United States. The medal, sponsored by Wyeth Incorporated, Philadelphia, pharmaceutical house, has been awarded annually since 1942 for outstanding work in preventive medicine for the armed forces.

7 features

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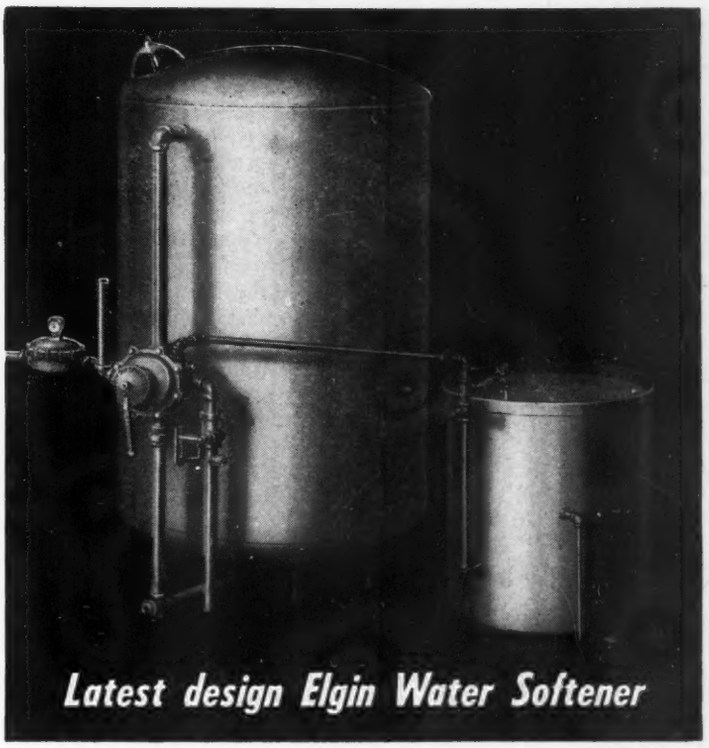

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Unbiased surveys prove that with ELGIN quality construction throughout, fewer replacements are required. Loss of zeolite is prevented, thus eliminating costly additions.

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Efficient distribution, collection and regulation of water and brine add years to the life of Elgin Water Softeners.

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To give the same capacity as an Elgin, other water softeners must be as much as 50% larger in size.

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BENEFITS AND SAVINGS OF SOFT WATER IN THE HOSPITAL

In hospitals, perhaps the number one use for soft water is in the laundry. But it's only one of many profitable uses. In the boiler room, soft water stops scale and lime deposits, cuts boiler cleaning and maintenance costs and reduces fuel costs. It also prevents such hard water deposits in hot water heaters and piping — reducing maintenance and replacement expenses. Soft water makes dish washing easy —assuring clean, sparkling dishes and silver. Boiled foods and beverages taste better when prepared with soft water. Hard water scale and lime damages costly sterilizer equipment and forms objectionable deposits on instruments. Soft water stops all this. Soft water gets things cleaner with less rubbing and scrubbing—makes everything look clean and bright as it should in a hospital. Cuts soap costs in half, too.

Elgin gives you the *extra* water for these services without installing larger equipment.

Existing water softeners of any make can be modernized by Elgin to provide the above features.

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SOFTENERS ★ FILTERS ★ WATER TREATMENT ★ BOILER WATER CONDITIONING

New York Hospitals Will Aid Veterans

Voluntary hospitals in Greater New York are being asked to coooperate by making available for the care of veterans in need of hospitalization 500 beds during the next year to two years. There is an acute shortage of beds in the veterans' facility in this area, it seems. It was recommended to member hospitals of the Greater New York Hospital Association and approved by their representatives at a recent meeting that they accept from the government for the care of veterans in their hospitals the Workmen's Compensation rates now in effect, which are based on the average costs of the hospitals.

On the same occasion it was revealed that following conferences between a special committee of the association formed to consider a rate schedule for polio cases an agreement has been reached with the National Foundation for Infantile Paralysis whereby a rate of $7 per day will be paid for in-patients and $2 per clinic visit. Heretofore, the New York Chapter of the National Foundation has been paying the hospitals $1.50 per day for bed and board for polio cases and $4.50 per day for patients receiving the Kenny treatment.

The question of the establishment of a placement and counseling service for nurses in the New York area is considered to be pressing at this time. This is particularly important in view of the present shortage of nurses and the impending demobilization of some 56,000 nurses from the armed services. Plans of the United States Employment Service include expanding its placement service for nurses. On the other hand, it is the feeling of the nurses' organizations that counseling and placement of professional nurses should be under the jurisdiction of the professional nursing groups. Member hospitals of the New York association are considering to what extent they should provide financial support for the nurses' program.

The recently organized course in hospital administration now being given at Columbia University is getting off to a good start, according to reports. This has been made possible through a grant made by the Kellogg Fund for three years and possibly five.

To Build Nurses' Residence

The regents of the University of Texas have announced completion of arrangements with the Sealy and Smith Foundation for the John Sealy Hospital, Galveston, Tex., to construct a $250,000 addition to the Rebecca Sealy Nurses' Residence at the Medical Branch.

20,818 Public Health Nurses

The United States has a present total of 20,818 public health nurses, according to an article prepared by the National Organization for Public Health Nursing for a recent issue of *Public Health Nursing* magazine. The total, which is based on statistics supplied by the U. S. Public Health Service, indicates one public health nurse for every 8300 people. The distribution according to population varies in different sections of the country, however, ranging from one public health nurse for every 2900 people in an eastern state to one for 18,300 in a southwestern state. The minimum standard accepted by health authorities is one for every 2000 to 5000 population.

Issues "Story of Brucellosis"

In keeping with its program of seeking to increase the public understanding of various crippling and handicapping diseases, the National Society for Crippled Children and Adults, Inc. has made a new addition to its series of publications. "Crippler in Disguise: The $20,000,000 Story of Brucellosis in America" is the new pamphlet which, Lawrence J. Linck, executive director, says, will be of particular interest to public health agencies and public health personnel.

"Help Your Hospital" Is Theme of Drive by War Council

The War Advertising Council, in cooperation with United States Public Health Service, Veterans Administration hospitals, War Manpower Commission, American Red Cross, American Hospital Association and National Nursing Council for War Service, is sponsoring campaigns to aid hospitals in obtaining personnel and veterans in obtaining jobs.

Booklets have been issued by the War Advertising Council and are available from the National Publishers Association, Inc., 232 Madison Avenue, New York 16, N. Y., outlining advertising campaigns which are two-fold in purpose:

First, to awaken the community to the needs of the hospital, if it is to continue to render service to the community, and to the assets as well as the needs of the veteran in returning to his place in civic life; second, to help the advertiser by suggesting themes for copy which will create good will.

Send Patients to Own Doctors

Mount Carmel Mercy Hospital, Detroit, is requesting its patients to go back to their former physicians who have been serving with the armed forces. A placard, bearing the following announcement, has been distributed to members of the hospital staff for display in waiting rooms:

"If you have been a patient here because your doctor has been a member of the armed forces, we suggest that you contact him upon his return."

Nurses' Guild Holds Meeting

The General Council of the Guild of St. Barnabas for Nurses held its annual meeting at the Church of the Advent in Cincinnati on October 20 and 21.

Founded in 1886 in Boston by Rev. Edward William Osborn, D.D., who later became the Bishop of Springfield, the guild has a three-fold program including spiritual, social and cultural activities for nurses and student nurses.

In addition to the chaplain of each branch who guides members in their activities, the guild provides a place for associates who are lay women, and physicians who are interested in the welfare of nurses. Rev. John Goodridge Martin, S.T.D., administrator of the Hospital of St. Barnabas and for Women and Children, Newark, N. J., is chaplain-general.

Newspaper Advertising Is Public Relations Medium for Hospital

To improve public relations and gain appreciation of the community contribution made by the hospital, Vassar Brothers Hospital, Poughkeepsie, N. Y., has been running a series of advertisements in the local paper. The title of the series is "What Vassar Brothers Hospital Means to You," and the copy is institutional in nature, describing the good works accomplished by the institution.

From the letters and personal comments received, the hospital believes that the campaign has built good will although a longer period of time will be required for the final answer. The cost of the advertising was assumed by individuals interested in the welfare of the institution.

Discuss Problems of the Blind

"Current Problems in the Welfare and Rehabilitation of the Blind," a course consisting of a coordinated series of lectures to be given by experts in their fields, will be conducted at Columbia University, Teachers College, New York City, by Dr. Berthold Lowenfeld, director of educational research of the American Foundation for the Blind.

WAX MAKES THE DIFFERENCE

in this patented finish!

JOHNSON'S WAX-FORTIFIED INTERIOR FINISH gives you these 4 extra advantages!

1 *Greater mar resistance.* Remarkable ability to withstand scuffs and scratches.

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The Johnson laboratories have perfected this new patented Wax-Fortified maintenance finish which gives a rich, no-glare beauty, is exceptionally dirt- and wear-resistant, and amazingly easy to clean.

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Johnson's Wax-Fortified Interior Finish is thoroughly impregnated with wax which is evenly distributed *all through* it, not just on the surface. As a result, the wax protection lasts as long as any finish remains — steps up maintenance efficiency, cuts maintenance costs. No special preparation is necessary for application. Brushability is improved because of the lubricating action of the wax. Broad coverage and great hiding power make for true painting economy.

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Its versatility and special advantages mean that Johnson's Wax-Fortified Interior Finish will fit the needs of bakeries, food plants, dairies, restaurants, factories, office buildings, department stores, schools and hospitals. For the complete story, fill out and mail the coupon today!

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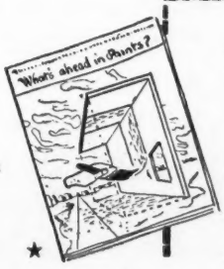

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Gentlemen: Sure! "Wax Fortified" looks good to me. I'd like to see the "What's Ahead in Paints" brochure.

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TB Conference in Chicago

A conference on the control of tuberculosis in a metropolitan area was held on November 13 and 14 at the Palmer House in Chicago. The conference was sponsored by the Institute of Medicine of Chicago in association with the Chicago Medical Society, the Tuberculosis Institute of Chicago and Cook County, Council of Social Agencies of Chicago and the Chicago Tuberculosis Society. Among the speakers was Dr. Herman E. Hilleboe, chief of the tuberculosis control division of the U. S. Public Health Service in Washington. His subject was "Case Finding."

Grant Funds for Polio Care

The Davidson County Chapter of the National Foundation for Infantile Paralysis, Inc., Nashville, Tenn., has appropriated $4250 for physical therapy equipment for the treatment of poliomyelitis in the Hubbard Hospital for Negroes at Nashville.

Dr. M. Don Clawson, president of Meharry Medical College for Negroes at Nashville, told chapter officials that the college will employ a full-time technician to operate the equipment at the hospital. The arrangement also will provide clinical experience for Meharry students.

Offers Course in Industrial Medicine

The fourth postgraduate course in industrial medicine will be given at the Long Island College of Medicine under the auspices of the Department of Preventive Medicine and Community Health by a group of distinguished leaders in industrial medical practice, authorities in allied fields and members of the faculty of the college during a three week period, January 14 to February 1.

The main objective of the course, as in the past, is to provide physicians wishing to enter industrial medicine, as well as those now engaged in this type of practice, an opportunity to become familiar with modern medical procedures and the more recent developments in this fast developing specialty.

New Hospital at Texarkana

Construction of the new $750,000 Michael Meagher Memorial Hospital at Texarkana, Ark., was inaugurated recently with the Most Rev. Albert L. Fletcher, D.D., Auxiliary Bishop of Little Rock, officiating at the ceremony of blessing and breaking of the ground. The new hospital, of reenforced concrete, will consist of two units, a main four story and basement hospital building and a one story service building. It will be erected opposite the present building. The hospital is conducted by the Sisters of Charity of the Incarnate Word, and Sister Mary Baptista is Superior of the institution.

New Hospital for Riverhead

A new nonprofit and nonsectarian hospital is promised for Riverhead, N. Y. The first step toward its erection has been taken by the Riverhead Hospital Association in inaugurating a campaign to raise $100,000 for a charter. According to latest reports, preliminary requirements have been met and a building fund campaign will start as soon as pledges are received for the initial amount.

Wisconsin Reenrolls Veterans

The more than 5000 returning servicemen from Wisconsin who held membership in the Blue Cross Hospitalization Plan may resume their status where they left it on induction, L. R. Wheeler, executive secretary of the Wisconsin Blue Cross office, has announced. A veteran must reenroll within 40 days of his discharge, however, to obtain credit for previous membership. If the veteran is married, he may enroll his dependents.

"we cut meal-serving costs 4 ways with... DIXIE CUPS"

Individual Dixie Cups save washing, rinsing, sorting, and sterilizing ... Save breakage ... Save food waste, through better portion control ... Save "time out" for staff illness caused by mouth-carried infections. Use clean, noiseless Dixies for staff dining rooms, diet kitchens and trays—and you save time and money, all along the line.

DIXIE CUPS, VORTEX CUPS AND PAC-KUP CONTAINERS ARE MADE AT EASTON, PA., CHICAGO, ILL., DARLINGTON, S. C., TORONTO, CANADA

Set Up Center for Polio Care

New York City's first medical center for the specialized training of doctors, nurses and other professional personnel in the treatment of infantile paralysis has been set up at Knickerbocker Hospital where the unit occupies the entire fifth floor. The New York chapter of the National Foundation for Infantile Paralysis has established a budget of $425,000 for special equipment and treatment, and the national organization has appropriated $100,000 for educational aspects of the work. Patients unable to pay regular hospital charges will be assisted financially by their respective local county chapters.

A.C.S. Lists Graduate Programs

A special edition of the *Bulletin* has been prepared by the American College of Surgeons and dedicated to its present and future fellows who have given service to their country during World War II. The officials of the college hope that the information assembled in the publication will be of value to doctors in military service in planning their postwar careers. A detailed announcement regarding the directory of approved plans of Graduate Training in General Surgery and in the Surgical Specialties appears in the bulletin.

Adopt Surgical Insurance Plan

Approval of a hospital-surgical insurance plan sponsored by a group of casualty companies was announced by the Wisconsin State Medical Society at its annual house of delegates meeting October 23. The plan provides cash reimbursements for hospitalization expense and offers a standard schedule of indemnities for surgical procedures. The plan will be sold on a group basis with monthly premiums paid through employers. Underwriting is divided according to a cooperative arrangement among seven insurance companies operating in Wisconsin and the Middle West.

Largest Class of Women M.D.'s

The largest class of first year woman medical students in the country is claimed by the University of Illinois, with 36 women in a class of 166. Women in the class average three years older than the men, a university announcement says, because many of the women worked as technicians in laboratories before becoming interested in medicine. Women are capable students and do satisfactory work in every respect, a university official stated, except that they often get sidetracked into domesticity. "The chief trouble with women in medicine is matrimony," he declared.

Medical Care for Farmers

Few farm families subscribe to prepayment plans, according to a report entitled, "What Farm Families Spend for Medical Care," prepared by the Bureau of Human Nutrition and Home Economics of the United States Department of Agriculture under "Miscellaneous Publication No. 561." Among urban families the percentage of those who buy prepaid medical care increases with income until incomes exceed $5000. Village families follow the same pattern but with a smaller percentage of subscribers at all income levels; the highest percentage of prepayment subscribers among farm families, however, is among the low-income families.

Army Nurse Film Released

"The Army Nurse," Miscellaneous Film No. 1173, is a new War Department film designed to answer many questions that will confront the new graduate who seeks an Army career and to inform young women of the opportunities for service. Completed by the Army Signal Corps Photographic Center, the film is being distributed to film libraries throughout the Army and will be made available to schools of nursing through the Service Command film libraries for use in nursing classes.

OFFICIAL ORDERS
October 18 to November 18

Cheese.—A method for establishing manufacturers' dollar-and-cent prices for all processed cheese, processed cheese foods and processed cheese spreads, not previously covered, was announced October 18 by the O.P.A. There will be no price increase to consumers.

Dried Prunes and Raisins. (Natural condition unpacked)—No longer are these dried fruits under price control. Their removal came under a directive issued by the Office of Economic Stabilization after it was found that continuation of ceiling prices on these commodities was no longer necessary. Effective date, October 23.

Drugs.—Among chemicals and drugs exempted from price control on October 16 are the following: botanical drugs, domestic and imported, whether crude, milled, ground or powdered, or in solid fluid and powdered extracts, used in medicinals, aromatics and insecticides; Gum Gha ti, an import used in adhesives and binders; several chemicals used in the manufacture of drugs and chemicals, and saponin, used in the manufacture of soap.

Construction Materials.—Regional administrators of O.P.A. may now authorize district directors to establish uniform ceiling prices on some essential building materials in localities where construction is about to be resumed. The community dollar-and-cents ceilings will reflect the general level of prices under the applicable regulation, according to O.P.A. Amendment No. 10 to revised maximum price regulation No. 293 says that contract sales of sash, screens, wooden stairways and other a lied wooden components used in building construction may not be made at prices higher than the seller charged in March 1942.

Price Controls.—According to an announcement made by the O.P.A. on October 26, price controls were lifted from 52 miscellaneous food commodities, ceilings were suspended for a ninety-day period on three other commodities and suspended indefinitely on a fourth, on October 31. The foods affected fall into various categories: frozen fruits and vegetables, dehydrated vegetables, dried fruits, bakery products, grocery specialties, fish, fats and oils, and miscellaneous.

Priorities.—War food order 73, put in force to help Marine hospitals procure restricted foods, was terminated October 31.

Rationing.—Point values on such items as butter, margarine, lard, shortening and oils were sharply reduced October 28—from 12 to 8 points a pound. Nearly 100,000,000 pounds of butter from government stocks was returned to civilian trade channels beginning November 1, the U. S. Department of Agriculture announced recently. Beginning with the November-December period, the O.P.A. said that institutional users would get their bi-monthly allotments of rationed foods from O.P.A. district offices rather than from local boards. This amendment 121 to General Ration Order 5 was effective November 1.

Rice.—The 1945 United States crop of rice is record production but the allocation to civilians is somewhat less than usual for the final quarter of 1945. The world supply is short in terms of world demand and, in line with an agreement made by Canada, the United States and Great Britain, rice is being distributed among countries where it is a very important food item.

Rubber Goods.—Under a November 2 amendment to Rubber Order R-1, one of several regulations left in force as W.P.B. went out of existence and its remaining functions were taken over by a successor agency, the Civilian Production Administration, manufacturers of first quality lightweight natural rubber or natural rubber latex gloves, may supply only institutions which certify that such gloves are required for use in the practice of medicine. A separate certification must accompany each purchase order. The amended order also specifies the percentage of natural rubber that manufacturers may use in making gloves, ice bags, syringes, cushions and other hospital and surgical articles. Many items essential in the rehabilitation of wounded veterans will benefit from the more liberal use of rubber now allowed.

Sauerkraut.—Amendment 4 to supplementary order 132 of the O.P.A. removes sauerkraut, both canned and bulk, from price control. The estimated crop of cabbage for this year should be large enough to maintain prices of sauerkraut at present levels during the coming year, O.P.A. added.

Sugar.—Under an October 30 amendment to General Ration Order 5 it is explained that institutional users of sugar must apply for allotments for each period for which they are needed. The allotment establishes the user's right to get rationed food and is not just a method of obtaining it, the order states. Thus a user may need an allotment even when stocks on hand are adequate. Applications for allotments are to be made to the district O.P.A. office in person or by mail during the first fifteen days of each allotment period on O.P.A. Form R-1309 (Revised), and allotments will be issued after the sixteenth day. Later applications may be received, at the discretion of the District Office; in this case the allotment will be reduced by an amount corresponding to the part of the period that has elapsed at the time of the application.

Surplus Property.—A regulation issued by the Surplus Property Administration says that public health institutions may buy surplus property at a discount whether the purchase is made by the institution itself or by a state or local government acting on its behalf. This discount is to be 40 per cent from the "fair value" of the property and is designed to channel goods on the basis of need to hospitals, medical or sanitational institutions, and some other nonprofit organizations. The United States Public Health Service, operating within the Federal Security Agency, will handle and review cases involving medical institutions. A certificate will be required with each application stating that the property is for the applicant's own use to fill an existing need and further, that the property will not be resold within a period of three years from the date of purchase without the written consent of the disposal agency.

ABOUT PEOPLE

(*Continued From Page 90*)

the National Executive Housekeepers' Association.

Grace Zerbolio, administrative dietitian at St. Luke's Hospital, Chicago, since 1941, has been promoted to director of dietetics. She succeeds **Frances Ware** who resigned.

Ralph M. Eyler has assumed his duties as pharmacist in charge of the drug room at Wesley Hospital, Wichita, Kan. Mr. Eyler received his training at Brunswick School of Pharmacy, Brunswick, Mo. Prior to going to Wichita, he owned and operated a drugstore at Newton, Kan.

Alta Nelson, R.N., has been appointed superintendent of nurses at Dodge County Hospital, Fremont, Neb., succeeding **Mrs. Marie Saeger** who resigned. Miss Nelson was supervisor of the obstetrical department at the hospital for the last two years and will be succeeded in that position by **Adeline Willgohs, R.N.**

Carolyn Knowles, who recently completed a year's internship at the University of Oregon Medical School and Hospital following her graduation from Marymount College, Salina, Kan., has been named chief dietitian at St. Catherine's Hospital, Omaha, Neb. The new assistant dietitian is **Bernice Barnett,** graduate of the University of Iowa.

Mrs. Henrietta Trenery has been appointed director of nurses at Hackley Hospital, Muskegon, Mich.

Josephine C. Barbour has been named chief of the social service department of Massachusetts General Hospital in Boston. She succeeds **Ida M. Cannon** who is retiring.

M. Isabel Foster, formerly associated with Strong Memorial Hospital, Rochester, N. Y., has become chief dietitian, Newton-Wellesley Hospital, Newton Lower Falls, Mass.

Everett S. Rubinstein, supervisor of pharmacy, purchasing agent and administrative assistant at Mount Sinai Hospital, Cleveland, was recently honored by receiving the annual Frank E. Chapman award given each year to a member of the personnel for meritorious service. The formal presentation of an engraved scroll and honorarium was made by **Max Myers,** president of the board. Mr. Rubinstein has been in the service of the hospital since 1920.

Lt. Col. Dale K. Tuller has been appointed administrative assistant in charge of Columbia-Presbyterian Medical Center's food service. Colonel Tuller is now on terminal leave from the Army. Prior to joining the Army, Colonel Tuller spent twenty years in the hotel catering field.

Trustees

Sidney L. Schwarz has been elected president of Michael Reese Hospital, Chicago, succeeding **Harry M. Gottlieb.** Mr. Schwarz has been a member of the board of trustees of the hospital for twenty-five years.

Dr. Harry Woodburn Chase, chancellor of New York University, and **Brig. Gen. F. Trubee Davidson** have been elected to the board of directors of Memorial Hospital, New York City.

Miscellaneous

Comdr. Daniel Blain, U. S. Public Health Service psychiatrist, has been appointed director of the Veterans Administration neuropsychiatric services, according to an announcement by **Gen. Omar N. Bradley,** Administrator of Veterans' Affairs. Commander Blain's responsibilities will include supervising the care of 61 per cent of Veterans Administration patients and establishing mental hygiene clinics in the 53 regional offices of the agency. During the war, Commander Blain was assigned to the War Shipping Administration.

Col. Leon L. Gardner has been appointed director of the Army Medical

Library, succeeding **Col. Harold W. Jones** who will soon be retired from active duty, the Office of the Surgeon General has announced. Colonel Gardner was formerly in charge of public relations and military intelligence, Office of the Surgeon General.

Joseph Blumenkranz, who recently returned from Puerto Rico where he was associated with **Richard Neutra** in planning hospital construction, has opened offices as architect and hospital consultant with **Sidney L. Katz** and **Taina Waisman** at 327 Lexington Avenue, New York City.

George H. Miehls has been elected president of Albert Kahn, Associated Architects and Engineers, Inc., of Detroit, succeeding the late **Louis Kahn.** The former executive vice president was also elected as treasurer of the forty year old firm.

Lt. Col. George A. Wiltrakis of Chicago has been appointed by Governor Green of Illinois to succeed **Dr. Conrad Sommer** as deputy director in charge of mental hygiene service for the Illinois Department of Public Welfare. Doctor Wiltrakis is a surgeon by training but held various assignments in the welfare department for eleven years preceding his entrance into military service and has served as head of the Association of State Hospital Physicians.

Watson B. Miller has been nominated by President Truman for the post of Federal Security Administrator to succeed **Paul V. McNutt,** now high commissioner to the Philippines. Mr. Miller served as Assistant Federal Security Administrator for four years and prior to that assignment was national rehabilitation director for the American Legion for eighteen years.

Col. Howard A. Rusk of the Army Medical Corps has been appointed consultant on physical rehabilitation for the Baruch Committee on Physical Medicine, it has been announced. As chief of the Convalescent Division of the Office of the Air Surgeon, Colonel Rusk won national attention with his pioneering work. His headquarters will be at the New York office of the committee.

Robert V. Fortune has been appointed executive director of the Hospital Service Association of Montana, Helena, Mont.

G. Donald Buckner of Worcester, Mass., has been named secretary of the Tuberculosis Committee of the New York Tuberulosis and Health Association, 386 Fourth Avenue, New York City. The new secretary will be responsible for all phases of the association's anti-tuberculosis program in Manhattan.

Maj. Gen. George C. Dunham will succeed **Nelson A. Rockefeller** as chairman of the board of directors of the Institute of Inter-American Affairs. General Dunham, who has served in the Army Medical Corps since 1916, recently resigned as president of the institute and deputy director of the Office of Inter-American Affairs for reasons of health. General Dunham's successor is **Col. Harold B. Gotaas,** Chapel Hill, S. C., former director of the Health and Sanitation Division of the institute.

W. Crane Lyon has reopened his office as hospital consultant at 744 Broad Street, Newark, N. J.

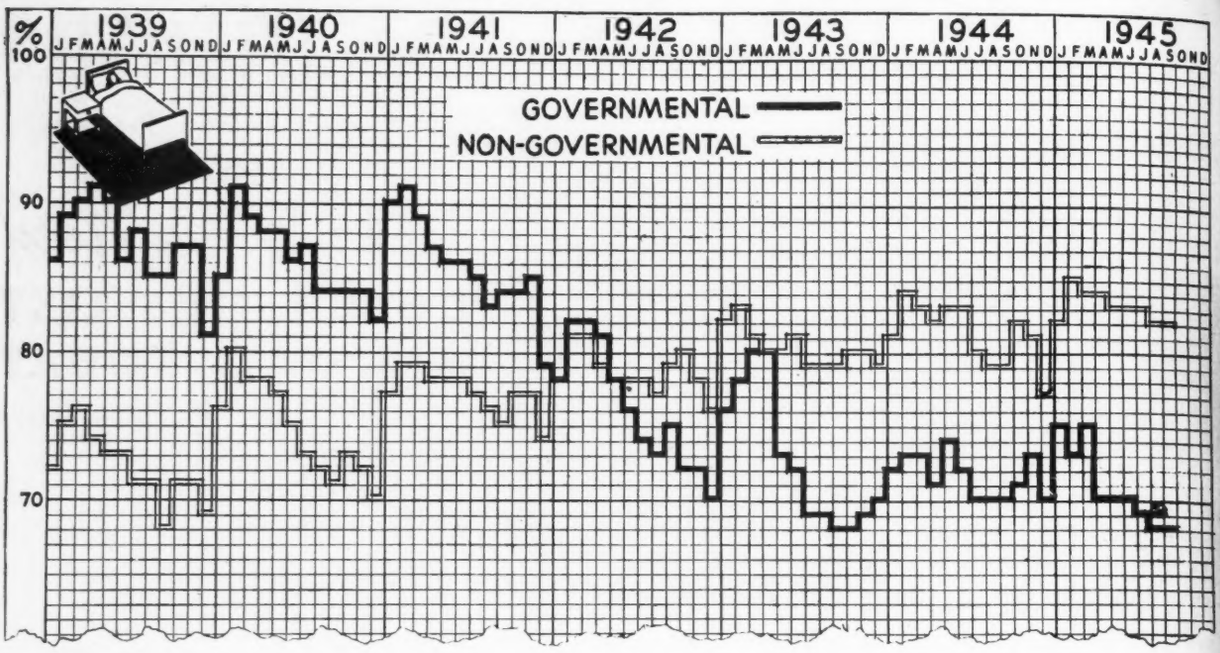
Reginald R. Isaacs, architect and city planner, has been appointed director of planning for Michael Reese Hospital in Chicago.

Deaths

Dr. Laura E. McClure, medical director, Babies Hospital, Philadelphia, died at the age of 40.

Henry T. Brandt, superintendent of Deaconess Hospital, Buffalo, N. Y., died of coronary thrombosis in his room at the Drake Hotel, Chicago, during the morning session of the A.H.A. House of Delegates meeting, November 6. Mr. Brandt left the meeting and a short time later succumbed. He was a past president of the Western New York State Hospital Association and was treasurer of the Hospital Service Corporation of Western New York.

Construction Projects Total $226,160,676



September occupancy in nongovernmental hospitals remained at 82 per cent, the same figure as for August, according to preliminary reports. Governmental hospital occupancy also remained static at 68 per cent.

Construction projects, however, were anything but stationary; 54 institutions reported new projects, with 48 of them giving costs of $41,338,781 between September 17 and October 15, bringing the total for the first ten months to $226,160,676.

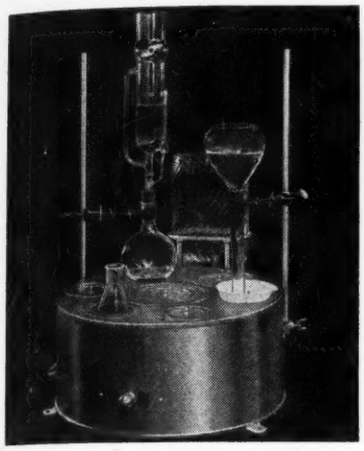
New hospitals accounted for the greater part of the total, with 21 out of 23 reporting costs of $32,615,000. Twenty-six additions are planned, with 23 reporting costs of $6,510,000. Two alteration jobs and three nurses' homes (two reporting costs) will cost $60,000 and $700,000, respectively.

What's New for Hospitals

NOVEMBER 1945 SUPPLEMENT TO THE MODERN HOSPITAL

Portable Water Bath

A new electrically heated water bath has been developed which features an automatic bottle feed that makes the unit



portable. Other improvements include an inside shelf for immersion heating, rod clamps permanently mounted, test tube holder, flush mounted switches and a pilot light. Lined with tinned copper, the bath has Monel Metal exterior and is 7 inches high, 15 inches in diameter, 15 inches high to top of bottle and requires bench space of 18 by 21 inches.

Scale formation can be prevented inside the bath by the use of distilled water. The new automatic bottle feed will operate for more than 10 hours on low heat and 4 to 5 hours on high heat. The test tube holder has 14 holes of ⅝ inch diameter for tubes, and openings in concentric covers range from 1-3/16 to 5-3/16 inches in 1 inch intervals. When setting up for extractions and concentrations the rod clamps save working space. Rubber hose connectors for continuous operation from running water supply are available when desired. **Barnstead Still & Sterilizer Co., Inc., Dept. MH, 31 Lanesville Terrace, Boston 30, Mass. (Key No. 2865)**

Two-Speed Hand Drill

A new two-speed hand drill with thumb tip control has been developed by Zimmer Manufacturing Company. The drill features both high and low speeds and can be used for driving screws, reaming, drilling and inserting Steinman pins. It can also be used with Jacobs Chuck. **Zimmer Mfg. Co., Dept. MH, Warsaw, Ind. (Key No. 2877)**

Food Container Sterilizer

The AerVoid Sterilizer, Rinser and Preheater is designed for cleaning and sterilizing food carriers and similar large utensils for handling foods. A simple device with a spray nozzle which flushes and cleans the container with a forceful rinse of cold water, then a strong spray of hot water and finally a sterilizing stream of steam, this AerVoid unit is completely foot operated, thus leaving the hands free for handling the utensils being cleaned and sterilized. Any utensil with a top diameter up to 20 inches can be handled by this device which can also be used for preheating carriers before they are filled with food. **Vacuum Can Co., Dept. MH, 19 S. Hoyne Ave., Chicago 12. (Key No. 2797)**

Hagie T-Stack

Orderly, convenient arrangement of artery forceps on the instrument table and nurse's supply table is possible with

the new Hagie T-Stack. Set up quickly, the T-Stack holds any size forcep and simplifies the selection and storage of instruments. The two sets of pins are adjustable to the various sizes and the T-Stack holds twelve or more forceps. The device can be sterilized with the instruments ready for setting up on the instrument or supply table. **V. Mueller & Co., Dept. MH, 408 S. Honore St., Chicago 12. (Key No. 2870)**

Dishwashing Compound

Turco Alfax is a new dishwashing compound designed for use in mechanical dishwashing equipment. Combining water softening activity with a high degree of active alkaline cleaning energy, Alfax prevents the formation of film, quickly removes oil and grease and rinses off completely. **Turco Products, Inc., Dept. MH, 6135 S. Central Ave., Los Angeles 1, Calif. (Key No. 2794)**

Aluminum Cubicles

New ARNCO cubicles of aluminum are a result of wartime product and material developments. The aluminum cubicle is strong, light in weight and simple to install and handle. Less ceiling stress is involved and extra strength and rigidity have been built into the corner bend assembly.

An improved arm goes into a reenforced connector with a heavy half inch projector at the point of attachment which supports the entire structure. Extra strength is provided by having all joints threaded. Curtains are pulled smoothly and quietly over the rods. The saving in weight of the new units results in economy in shipping costs. **A. R. Nelson Co., Inc., Dept. MH, 210 E. 40th St., New York 16. (Key No. 2914)**

Vim-Ogburn Surgical Stitcher

Built around the familiar ring-grip needle holder, the new Vim-Ogburn Surgical Stitcher permits speed, ease, convenience and safety in suturing. The Vim-Ogburn bobbin provides an ample supply of suture, two bobbins holding enough for any ordinary operation. The stitcher obviates the necessity for threading needles, changing needle-holders and repeated handling of the suture. An assortment of seven stainless steel needles is included with the stitcher.

A built-in two edged knife for severing sutures is part of this new instrument thus making it possible to be ready immediately for the next stitch without laying down the stitcher. When fiber

suture is used the entire instrument with threaded needle and filled bobbin can be sterilized. **MacGregor Instrument Co., Dept. MH, Needham 92, Mass. (Key No. 2868)**

Address manufacturers for further information and prices—or use Readers' Service blank on page 288

Meat Chopper

The new Toledo Meat Chopper has a gravity-feed construction which adds to the speed of operation by taking the meat from tray to cutters quickly and smoothly without mashing or heating. There is no back pressure of air and a sealed ball bearing absorbs all thrust, eliminating strain on the motor and avoiding severe wear. This new feature delivers more power to the cutters and provides faster, cleaner cutting. The direct, two-part constant mesh transmission gives positive, smooth quiet with oil-bath lubrication permanently sealed in and leakproof.

The stainless steel oversize tray covers the entire top of the machine, thus providing a large loading area. The feed hole in the tray at the operator's left hand corner makes it easy to feed the machine rapidly. The chopper is designed for

economy of space and for easy cleaning as well as for speed in operation. The white surface with gray trim is baked-on plastic that is bright, hard, easily cleaned and long wearing. **Toledo Scale Co., Dept. MH, Toledo 12, Ohio. (Key No. 2866)**

Microfilming Equipment

A new unit has been developed for microfilming records to facilitate storage and save space. Known as Flofilm, the microfilming camera and the processor for processing the microfilm are contained in one unit. The processor uses tubes and collects the microfilm automatically. It works in daylight and completely processes the microfilm without handling. The film is ready for reading within an hour.

The new device permits storage of records in either 16 mm. or 35 mm. sizes, takes copy of any length, and uses non-inflammable microfilm. The Flofilm camera prints positives without a dark room and operates electronically. **Flofilm Div., Diebold, Inc., Dept. MH, Canton 2, Ohio. (Key No. 2864)**

Waterproofed Apron

An improved, waterproofed apron has been especially designed for the use of

kitchen personnel in hospitals and other institutions. It is made of Hydro-Tex, a thoroughly impregnated, synthetic coated material especially treated to resist acids.

Designed for use by either men or women, the apron will not shrink, stick, peel or crack and remains soft and pliable. It is washable, is reenforced at all points of stress with cross stitching and is designed for long service and hard wear. The apron is equally suitable for laboratory personnel. **Hydro-Tex Corp., Dept. MH, 564 W. Adams St., Chicago 6. (Key No. 2829)**

Polarizing Microscope

A new type Polaroid is used in the new Spencer No. 42 Microscope which is a complete instrument for work with polarized light. The new Polaroid materials have been found to resist vapors and fumes in high concentration after thorough tests.

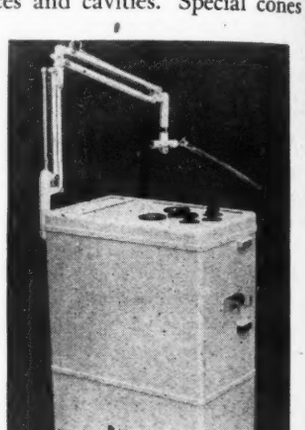
Sensitivity of the extinction point of the synthetic crystal system approximates that with calcite and other optical characteristics are closely parallel. The

amount of stray light is reduced through elimination of several glass-air surfaces and shorter length of the polarizing unit.

All of the advantages of the earlier model in the matter of heavy stand, adjustments and operation are incorporated in the new one. In addition, two retardation plates of plastic for determining the nature of double refraction have been developed through research and these accessories are also tested for vapor and heat resistance. **American Optical Co., Scientific Instrument Div., Dept. MH, 19 Doat St., Buffalo 11, N. Y. (Key No. 2830)**

X-Ray Unit

The new Philips Metalix Contact and Cavity X-Ray Unit is designed especially for use in treatment of certain diseases requiring application of x-rays to body surfaces and cavities. Special cones and



applicators provide a wide range of applications and the tube is easy to manipulate since it weighs but 11 pounds. The entire unit, including the tube and control, is constructed to protect the operator against electrical shock and stray radiation.

The special design and internal construction of the tube provide an intense x-ray beam with low inherent filtration. Accuracy of treatment time is provided through a built-in timer with a range from 5 seconds to 5 minutes. Control includes main switch, adjustment switch for line voltage, voltmeter, tube-filament control and milliameter. A flexible arm for mechanical positioning is part of the unit but the tube can be manipulated by hand. The unit is equipped with rubber tired wheels. **North American Philips Co., Inc., Dept. MH, 100 E. 42nd St., New York 17. (Key No. 2828)**

Pipette Suction Apparatus

The improved Adams Pipette Suction apparatus for use with red and white

Address manufacturers for further information and prices—or use Readers' Service blank on page 28

blood pipettes, Sahli pipettes and others with capacities of less than 1 ml. is chrome plated metal with a rubber adapter. A knurled knob at the end is turned to create the suction. Fine control of liquid level is afforded with this device and the dangers and inconveniences of mouth suction are eliminated. **Clay-Adams Co., Inc., Dept. MH, 44 E. 23rd St., New York 10. (Key No. 2782)**

Glass Washing Compound

Kelite No. 145 is a new white powder designed to eliminate calcium and magnesium scale in washing glasses. It can be used for either machine or hand washing and is maintained at maximum cleaning effectiveness in solution through pH control. The material rinses freely, leaving no deposit on the glasses. It is packed in 125 and 325 barrels. **Kelite Products, Inc., Dept. MH, 909 E. 60th St., Los Angeles 1, Calif. (Key No. 2783)**

Coffee Making Combination

A new combination coffee brewer, serving decanter and two burner electric stove with two heats, one for brewing and one for keeping coffee hot, has been designed by Cory and should prove useful in floor kitchens and service rooms in the hospital. The stove has chromium finish, plastic handles and heat control switches and the coffee brewer is of glass with plastic hinged cover and handle and plastic measuring cup. **Cory Glass Coffee Brewer Co., Dept. MH, 221 N. La Salle St., Chicago 1. (Key No. 2781)**

DDT Insecticides

. Two new insecticides containing DDT have been announced by the Vestal Chemical Laboratories. Vestaline Special contains 1 per cent DDT and is a quick killing contact spray. Lasto-O-Cide contains 5 per cent DDT for application to surfaces where its killing power continues for a considerable period of time.

Vestaline Special is a contact insecticide for the quick killing of flies, roaches, bedbugs, moths and other insects to which DDT has been added to increase its effectiveness. Last-O-Cide is designed for application to infested areas where its long lasting action is particularly advantageous. It is practically odorless and colorless and does not leave stains or odors. **Vestal Chemical Laboratories, Inc., Dept. MH, 4963 Manchester Ave., St. Louis 10, Mo. (Key No. 2873)**

PHARMACEUTICALS

Phenacaine Hydrochloride

Phenacaine Hydrochloride 2 per cent in a water miscible, rapidly spreading base for use as an anesthetic in painful eye conditions has been developed by the Upjohn Company. The same product with the germicide Mercarbolide added, for use where a powerful nonirritating antiseptic is desired in eye conditions, is also announced. Both products are supplied in 1 dram tubes with applicator tips. **Upjohn Co., Dept. MH, Kalamazoo 99, Mich. (Key No. 2751)**

Berocca Compound Tablets

A small, well tolerated tablet designed for the prevention and treatment of vitamin B complex deficiencies has been announced under the name Berocca Compound Tablet. Each tablet contains generous amounts of vitamins B_1, B_2, B_6, niacinamide and calcium pantothenate in a readily acceptable form. **Hoffmann-La Roche, Inc., Dept. MH, Nutley, N. J. (Key No. 2894)**

Penicillin Ointment

Topical application of penicillin is now possible through the use of the newly developed Penicillin Ointment Schenley. It can be used as an adjunct to systemic penicillin therapy and other measures in the treatment of superficial infections of the skin or in deep seated pyogenic infections. **Schenley Laboratories, Inc., Dept. MH, 350 Fifth Ave., New York 1. (Key No. 2896)**

Honey-B

A new B complex product designed especially for children contains the B complex vitamins in natural honey. Known as Honey-B, this pleasant tasting product can be used as a confection, spread on bread or crackers or mixed with milk or other liquids. It is supplied in 4 and 8 ounce bottles. **National Drug Co., Dept. MH, 4663 Stenton Ave., Philadelphia 44, Pa. (Key No. 2801)**

Estinyl Package

Estinyl, trade name for Schering's ethinyl estradiol, the potent oral estrogen, is now available in packages of 100 tablets to replace the former 30 and 60 tablet sizes. The 250 and 1000 tablet sizes will be continued as formerly. The new package is available in the same strengths of 0.02 and 0.05 mg. per tablet. **Schering Corp., Dept. MH, Bloomfield, N. J. (Key No. 2748)**

RECENT CATALOGS AND BOOKLETS

• **"A Step Ahead in Hospital Heating"** is the arresting title of Bulletin No. 633 issued by C. A. Dunham Co., 450 E. Ohio St., Chicago 11. Factual information of interest to the hospital administrator as well as to the engineering staff includes details on how Dunham Differential Heating operates, control of temperature and volume of steam resulting in fuel conservation, the importance of heating comfort in administration, low cost of operation and of maintenance and the handling of steam generating equipment. **(Key No. 2904)**

• Fifty years of service to the hospital field is summarized by the American Sterilizer Company, Erie, Pa., in a brochure entitled **"A Tribute to the Founders of American Sterilizer Company."** In addition to pertinent photographic presentations showing production of the sterilizers, lights and related equipment manufactured by this company, interesting data on the history of the company and photographs that will be familiar to many are included in this attractive, well planned booklet. **(Key No. 2900)**

• **"Taking the Horsefeathers Out of Vitamins"** is the title of a folder which is as clever and humorous as its name indicates and at the same time contains sound, helpful information on vitamin therapy as well as details on the vitamin products now available from Cutter Laboratories, Berkeley 1, Calif. You'll enjoy the clever drawings while you absorb the facts presented. **(Key No. 2899)**

• A pamphlet has been prepared describing the new **A.S.R. Sanitary Bed Pan Cover** developed by the surgeon's division of the American Safety Razor Corp., 315 Jay St., Brooklyn, N.Y. Made of easily disposable paper, the cover is designed to safeguard patients as well as personnel against exposure to cross infection and to unpleasant odors. Simple to use, the cover is inexpensive and efficient and eliminates the cost of laundry and lost or torn covers. **(Key No. 2898)**

• A new booklet giving full details on **Intocostrin,** purified extract of curare, has been issued by E. R. Squibb & Sons, 745 Fifth Ave., New York 22. In addition to description, indications, history, clinical applications and reports of clinical experience, a complete bibliography is included. **(Key No. 2856)**

• Maintenance engineers as well as hospital administrators will find much of interest and value in **Case Study No. 4, "A Study of Snow Removal,"** issued by A. M. Byers Co., Pittsburgh 30, Pa. **(Key No. 2859)**

Address manufacturers for further information and prices—or use Readers' Service blank on page 288

• To help you keep abreast of the literature published annually on vitamins, Abbott Laboratories, North Chicago, Ill., has published a 105 page book, **"Vitamin Therapy; A Resume of Clinical Experience."** Profusely illustrated with color photographs of clinical subjects, the booklet covers each vitamin or vitamin factor in a separate section and contains also a vitamin "chart" for quick reference or review of the essential facts regarding clinical indications, natural food sources, chemical formulas and other pertinent data pertaining to each vitamin. **(Key No. 2850)**

• A brief history of surgeons' needles with information on standardization, nomenclature, uses and types makes up the contents of a booklet entitled **"Needle's to Say"** issued by the Specialties Div., the Torrington Co., Torrington, Conn. **(Key No. 2817)**

• Full descriptive and illustrative information on **Diamond Soot Blowers** is contained in Bulletin 80 issued by Diamond Power Specialty Corp., 10340 Oakland Ave., Detroit 31, Mich. Details of parts, maintenance and operating instructions are included. **(Key No. 2913)**

TO HELP YOU get information quickly on new products we have provided this convenient Readers' Service Form. Check the numbers of interest to you and mail the coupon to the address given below. If you wish other product information just list the items and we shall make every effort to supply it.

Bessie Covert,
Editor, "What's New for Hospitals"

- ☐ 2748 Estinyl Package
- ☐ 2751 Phenacaine Hydrochloride
- ☐ 2761 Catalog 325
- ☐ 2781 Coffee Making Combination
- ☐ 2782 Pipette Suction Apparatus
- ☐ 2783 Glass Washing Compound
- ☐ 2794 Dishwashing Compound
- ☐ 2797 Food Container Sterilizer
- ☐ 2801 Honey-B
- ☐ 2807 "Eastern Stainless Steel"
- ☐ 2815 "Light From Floors"
- ☐ 2816 "Prevent Foaming of Fats"
- ☐ 2817 "Needle's to Say"
- ☐ 2828 X-Ray Unit
- ☐ 2829 Waterproofed Apron
- ☐ 2830 Polarizing Microscope
- ☐ 2847 "Color Dynamics"
- ☐ 2850 "Vitamin Therapy"
- ☐ 2856 Intocostrin
- ☐ 2857 "Rechargeable Flashlight Battery"
- ☐ 2859 "Study of Snow Removal"
- ☐ 2864 Microfilming Equipment
- ☐ 2865 Portable Water Bath
- ☐ 2866 Meat Chopper
- ☐ 2868 Vim-Ogburn Surgical Stitcher
- ☐ 2870 Hagie T-Stack
- ☐ 2873 DDT Insecticides
- ☐ 2877 Two-Speed Hand Drill
- ☐ 2894 Berocca Compound Tablets
- ☐ 2896 Penicillin Ointment
- ☐ 2898 "Sanitary Bed Pan Cover"
- ☐ 2899 "Taking the Horsefeathers Out of Vitamins"
- ☐ 2900 "Tribute to the Founders"
- ☐ 2904 "Step Ahead in Hospital Heating"
- ☐ 2913 Diamond Soot Blowers
- ☐ 2914 Aluminum Cubicles

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MAIL TO Readers' Service Dept., The Modern Hospital Publishing Co., Inc.
919 N. Michigan Ave., Chicago 11, Ill.

• A series of four-color booklets on the application of color dynamics principles has been developed by the Color Engineering Dept., Pittsburgh Plate Glass Co., 632 Duquesne Way, Pittsburgh 22, Pa. Of specific interest to you is the booklet entitled **"Color Dynamics for Hospitals and Institutions"** which discusses three important purposes of the hospital that can be accomplished by the scientific use of color as well as other interesting and helpful information on color. **(Key No. 2847)**

• Information on the **"Improved Greater Capacity Ideal Rechargeable Flashlight Battery"** is given in a folder recently issued by Ideal Commutator Dresser Co., Sycamore, Ill. **(Key No. 2857)**

• A 24 page booklet issued by the Universal Atlas Cement Co., 135 E. 42nd St., New York 17, features interesting information on white cement floors and their light reflecting qualities. Entitled **"Light From Floors,"** the booklet shows the use of this product for new floors and for retopping old floors in various types of buildings. **(Key No. 2815)**

• A leaflet entitled **"How to Prevent Foaming of Deep-Frying Fats"** contains helpful information which should prove of value to the dietitian and her staff. It is available through the Sparkler Mfg. Co., Mundelein, Ill. **(Key No. 2816)**

• The various uses for **Eastern Stainless Steel,** including hospital utensils and food handling equipment, as well as technical data of interest to engineers are given in an attractive 96 page, board bound catalog recently published by Eastern Stainless Steel Corp., Baltimore 3, Md. **(Key No. 2807)**

• **"Precision-Freas"** Constant Temperature Control Cabinets including sterilizers, incubators, humidity control, laboratory drying and other types are completely described and illustrated in the 48 page Catalog 325 recently issued by Precision Scientific Co., 1750 N. Springfield Ave., Chicago 47. **(Key No. 2761)**

Manufacturers' Plant News

The Levernier Laboratories, Syracuse, Ind., is a new corporation organized to serve hospitals through the manufacture and distribution of soap and alcohol dispensers. Announcement has come from Martin W. Levernier, president, who will be assisted in this new enterprise by his four sons. **(Key No. 2916)**

Eaton Laboratories, Inc., Norwich, N.Y., is announced as a wholly-owned subsidiary of the Norwich Pharmacal Co. developed to create and market therapeutical products through ethical channels. **(Key No. 2917)**

Printed in U.S.A.